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ABSTRACT

The five parts of this report present the findings and recommendations of the Migrant Child Welfare study. Part I briefly summarizes the impact of the child welfare services and the family interview results, and reviews the organizational structure of program delivery at the state and local levels. Part II synthesizes the information obtained from 12 states according to public social service agencies, child care, personal and environmental health, and education; gives an overview of that service to migrant children; and describes Federal and state funding sources which are, or can be, used to support child welfare efforts in each service area. Also reported are an assessment of migrant children's needs and the extent to which they are being met, a description of existing services which address these needs, factors which affect service delivery (program implementation, administrative structure, support, service coordination), and barriers of acceptability, availability, and accessibility which impede service delivery. Part III discusses the results of interviews conducted with migrant families concerning their use and need for specific child welfare services. Presented in Part IV are detailed summaries of the findings, with a description and discussion of the services at the state and local levels. Part V includes discussions of the existence of undocumented workers in the migrant stream and the need for advocacy of migrant programs; the results of the survey on training farmworkers in service to migrants; and two case studies which represent the best day care program and the worst living conditions for migrant families. (NQ)

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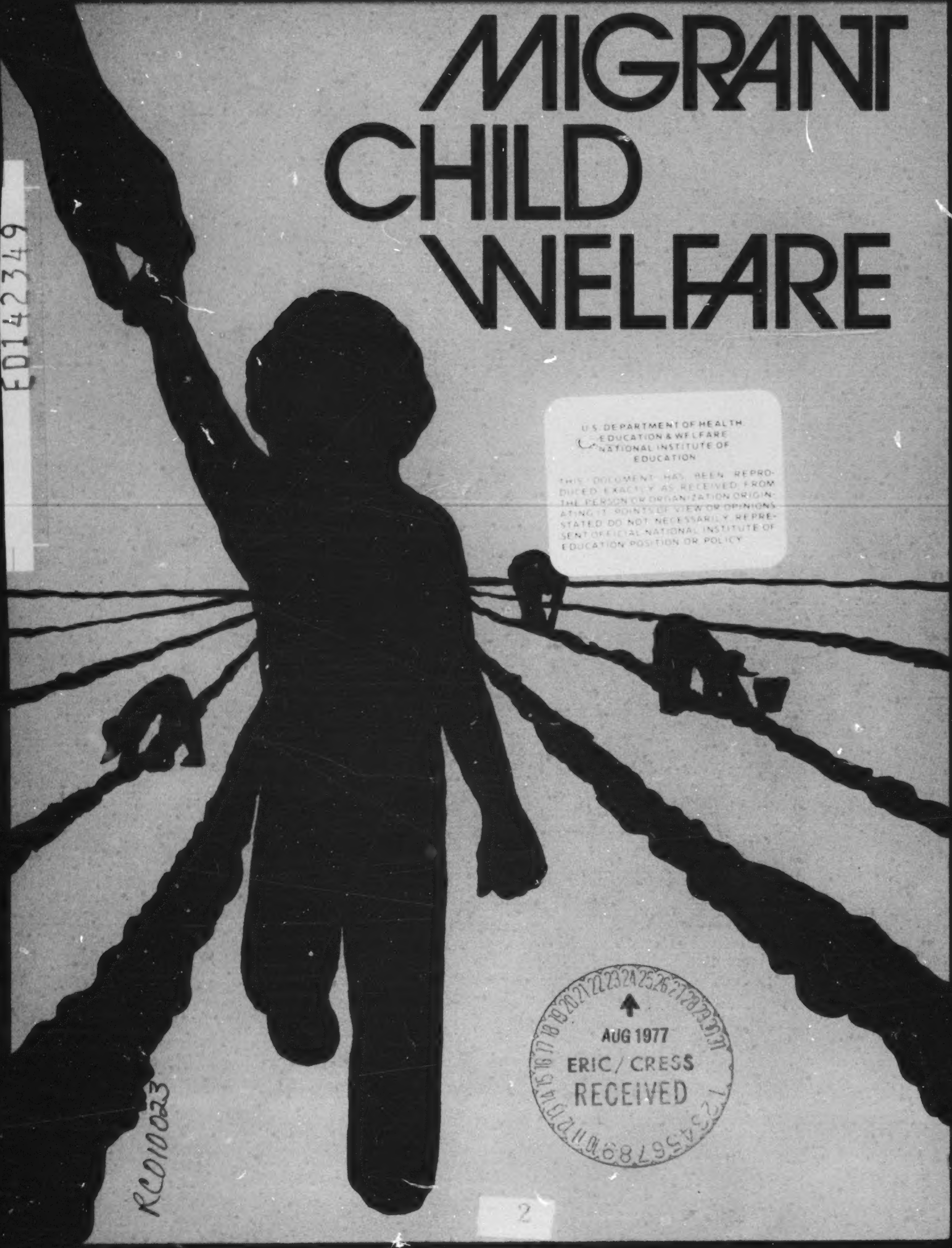
MIGRANT CHILD WELFARE



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MIGRANT CHILD WELFARE:

A State Of The Field Study Of Child Welfare Services For Migrant Children And Their Families Who Are In-Stream, Home Based, Or Settled-Out

FINAL REPORT

by

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FOREWORD

The two volumes comprising the Final Report of the State-of-the-Field Study of Child Welfare Services for Migrant Children and Their Families, entitled *Migrant Child Welfare* and *Migrant Child Welfare: Executive Summary*, present the findings and recommendations of this study.

The Migrant Child Welfare study was conducted for the National Center for Child Advocacy of the Children's Bureau, U.S. Office of Child Development, HEW, by InterAmerica Research Associates. It identifies and presents programs serving the needs of migrant families and problems in improving services to more adequately address these needs. The study found a critical shortage of data available on social services to migrants, and concluded as well that social services are seldom provided to migrant families to the same extent as they are to other populations. Child care and health services were more widely available but still met only a fraction of the need.

The study included a review of the literature, a survey of programs to train farmworkers in services to migrants, interviews with approximately 800 migrant families, and agency interviews in twelve states. Exemplary programs were identified which are currently serving migrant children and their families through child care, health, education and outreach services. The study highlighted as well a need for increased local-level coordination of services to the migrant population.

Migrants are denied a guaranteed minimum wage and the right to bargain collectively. They are often underpaid for work actually performed. They must migrate thousands of miles annually, often lacking food and even basic shelter. Recreation, support, and community involvement, which other Americans take for granted, are not available to these members of our society.

The Office of Child Development would like to express its thanks to the many families and agencies who cooperated in this study. We hope that through the study itself and through the use of this final report, its revelations will be helpful in obtaining improved services for migrant children and their families throughout the nation. The Children's Bureau acknowledges the commitment shown in the performance of this project by InterAmerica Research Associates, and wishes to indicate its own commitment to the pursuit of improved services for migrant farmworker families.

Helen V. Howerton

Helen V. Howerton, Chief
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Frank Ferro

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Children's Bureau

There are three publications as a result of the comprehensive "State-of-the-Field Study of Migrant Children and Their Families Who Are In-Stream, Home-Based, or Settled Out," prepared by InterAmerica Research Associates under the auspices of the National Center for Child Advocacy, Children's Bureau, Office of Child Development. They consist of the following:

- Migrant Child Welfare
- Migrant Child Welfare: Executive Summary
- Migrant Child Welfare: A Review of the Literature and Legislation

The interpretations, conclusions, and recommendations in this report are those of the authors and of InterAmerica Research Associates, and do not necessarily reflect or represent the views of the National Center for Child Advocacy, Children's Bureau; the Office of Child Development; or the Department of Health, Education, and Welfare.

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Helen V. Howerton, Chief of the National Center for Child Advocacy, Children's Bureau, OCD; E. Dollie Wolverton, Project Officer, NCCA; Hank Aguirre and Casimer Wichlacz of the Indian and Migrant Programs Division, OCD; other members of the Technical Review Panel for this study; the Regional Representatives of the National Center for Child Advocacy, Children's Bureau; and others in OCD and the federal government who assisted the project through reviewing materials and granting interviews.

The migrant families with whom we spoke deserve the most thanks for welcoming us into their homes and giving to us the information along with their perspectives on the services under study. We also wish to thank the representatives of the private and public agencies with whom we spoke in the eighteen counties and twelve state capitals we visited. Their cooperation and understanding of our objectives was supportive.

Those who contributed directly to the performance of the project and production of the results include Juan Gutierrez, president of InterAmerica Research Associates, Inc., and other members of the InterAmerica staff, who rendered time and suggestions; Lucy Conger and Wilfred Hamm who gave professional support at various stages of the project; Yolanda Hernandez, who provided continuity, coordination, and guidance to the project and its staff; and Charlotte Torres, Carol Cheleandar, and Robin Hill, who assisted in production.

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INTRODUCTION

INTRODUCTION

Migrant Farmworkers

The labor of migrant farmworkers is vital to agricultural productivity and the economy of the United States. A large number of farms and canning factories are almost totally dependent on migrant labor for picking crops and working in the food processing plants during the harvest season each year. All citizens benefit from the contribution of migrant labor to the economy, and while mechanization has somewhat decreased the need for migrant labor over the last decade, there continues to be a large number of crops which can be harvested only by the field laborer.

Despite the important contributions made by migrant farmworkers to the national economy and our food supply, migrants are among the most exploited and neglected of populations. This is reflected in the extremely low incomes of migrant families. The average hourly rate paid to farmworkers is less than half the average hourly wage of industrial workers (Pennsylvania Farm Labor Project, *Pennsylvania Farm Labor Plan*, Philadelphia: American Friends Service Committee, 1976, p. 9). Farmworkers work long hours under extremely hazardous conditions caused by pesticides, farm machinery, and inadequate sanitary conditions. Often, a portion of their wages are paid to crew leaders for food, transportation, and other services provided at inflated prices. This leaves the family with a woefully inadequate income derived from extraordinarily long days of very hard work. The average annual farmwork income of migrant workers in 1974 was less than $1,700; income from other work brought total annual income to about $3,100 (InterAmerica Research Associates, *Migrant/Seasonal Farmworker, An Assessment Of The Migrant And Seasonal Farmworker Situation In The United States, Vol. 2., Findings*, Washington, D.C.: InterAmerica Research Associates, 1976, p. 32). Child labor is an economic necessity for the migrant family due to the low level of income. By the age of four, most children work in the fields at least part of the day. And most older children drop out of school well before high school to work full-time in the fields.

The migrant lifestyle is characterized by almost continual traveling from one growing region to another, lack of sufficient food and other necessities, and crowded, unsanitary living conditions. Migrant workers typically travel from their home base areas in three major streams. The East Coast stream, which is traveled mainly by Black farmworkers and an increasing number of Mexican Americans, includes most of the states along the eastern seaboard. Most migrants traveling in this stream make their home in Florida while it is off-season in the northern states. The mid-continent stream is traveled mostly by Chicanos, and flows northward from Texas through the Midwestern and Western states. The West Coast stream moves within California and north to Oregon and Washington. In recent years, there has been more east-west movement, with migrant workers traveling in more than one stream. The travel patterns of migrant farmworkers are depicted in the chart on the following page.

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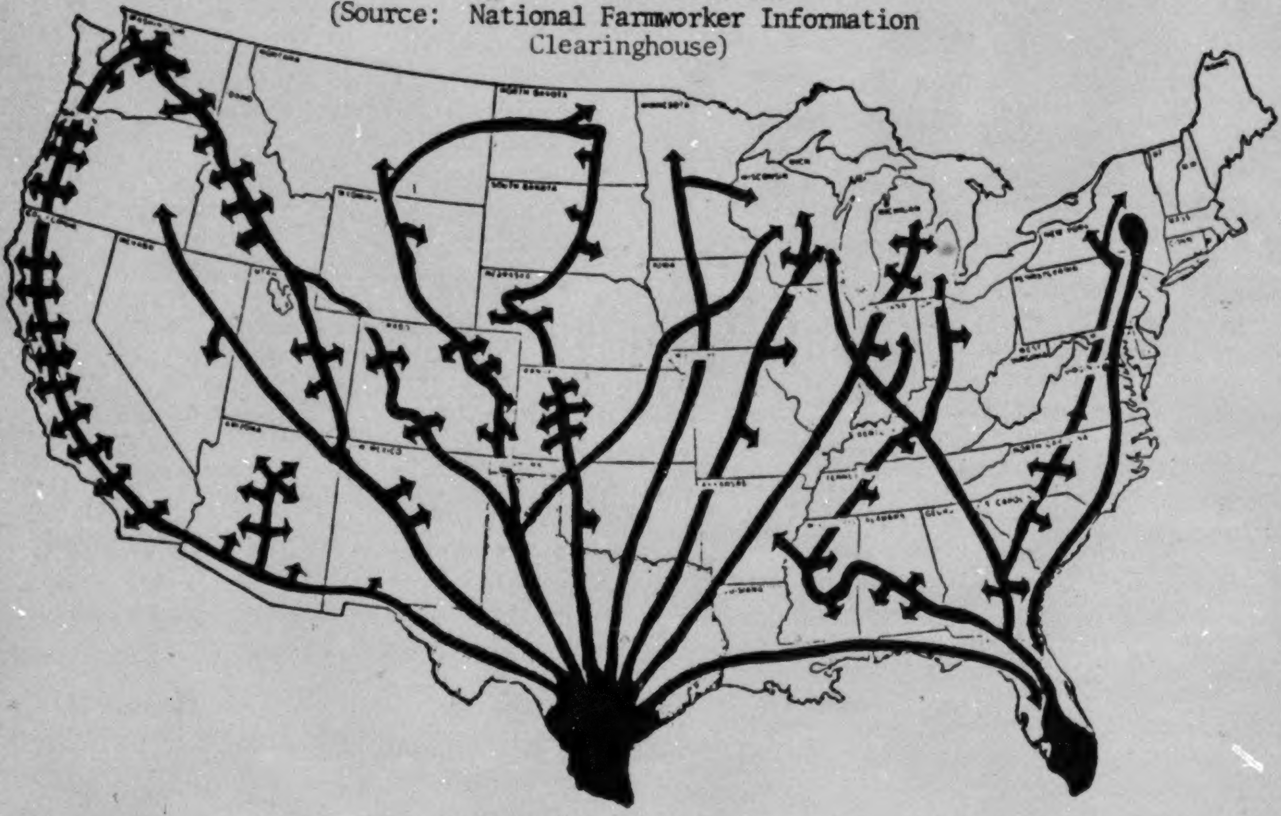
Migrant Travel Patterns
(Source: National Farmworker Information Clearinghouse)



Many migrants work in the stream for six to eight months. They travel in family groups, and most or all family members do some work in the fields. Others, however, travel as single people and leave their families at home. Some migrants are recruited in the home base areas and travel in crews. Others, "free wheelers," migrate independently as individuals. Migrant family size averages from 5.1 to 5.39 members and Mexican American families tend to be slightly larger than Black families (ibid., p. 38).

While there is no accurate method of counting farmworkers, it is estimated that there are over 800,000 migrants nationally, and most of them are very young (Baumheier, Edward C.; Gage, Robert W.; Hellar, Gretchen A.; and Theimer, C. Patricia. The Migrant Farmworker: Social Programs, Policies and Research, Denver: University of Denver, 1973, p. 6). In 1974, more than 60% of all migrants were under the age of 25, and only 2% were over 65 years old (InterAmerica Research Associates, Migrant/Seasonal Farmworker, p. 38). The average life expectancy for migrant workers is 49 years (Baumheier et al., The Migrant Farmworker, p. 9). This low life expectancy testifies to the migrants' hard lifestyle. The largest group of migrant farmworkers is Chicano, and the second largest is Black. Other racial/ethnic groups represented include Puerto Rican, Anglo, Native American, Mexican, Filipino, Canadian, and a small number of people from the West Indies.

Services to Migrants

The extreme poverty, high mobility, and detrimental camp and working environments of migrant farmworkers make them a group greatly in need of supplementary services. Their low income makes it virtually impossible to provide for their families' adequate food, clothing, and housing. Their needs, therefore, are immediate and very basic.

A variety of barriers exist, however, which impede migrants' receiving needed services such as health care, education, day care, and food supplements. Some of the barriers to service delivery are created by their occupational mobility, isolation, precarious employment, and economic exploitation. Other barriers stem from poor community response, discrimination, and inadequate legislative provisions, such as stringent eligibility requirements and waiting periods. Spanish-speaking migrants of limited English-speaking ability encounter problems in obtaining services because agencies often have no bilingual persons on their staffs. Continuity of service is also a problem as migrants move from area to area. Recently, several health and education record-keeping systems have been developed which attempt to compensate for this problem.

Many communities and state- and county-level agencies do not accept responsibility for serving migrant farmworkers who are in-stream since migrants are not permanent residents. Rather, it is asserted that the federal government has responsibility for providing services to migrants. Services provided by state departments of social service, state health departments, and similar agencies are usually available to migrants just as they are to permanent residents. However, unless outreach and bilingual staff are provided, the migrant families may not be aware of the services. In addition, they may have difficulties in proving their eligibility for the programs or in getting transportation from the migrant camps to the service provider. Therefore, social service agencies are not always so responsive and supportive as is required for a minority transient population with special needs.

Advocacy organizations are of great importance since migrant farmworkers have very little leverage for demanding that they receive the assistance to which they are entitled. They are politically powerless--a small, isolated, and transient group who are not members of a political constituency. Therefore, migrant farmworkers frequently are not covered by workers' protective legislation, or they are provided with much less extensive coverage than workers in other occupations. Also, many federal regulations are not flexible enough to serve a transient population.

Migrant Child Welfare Services

The goals and objectives of child welfare services, as described by the Office of Child Development, include the delivery of preventive, supplemental, and substitute care. Traditionally, the specific services proposed to meet these goals include adoption and foster care, residential treatment, institutional care, homemaker services, and protective services. In this study, child welfare is defined broadly to encompass more than the traditional child welfare services. The needs of migrant children, frequently more basic than the needs of nonmigrant children, stem from the ill effects of inadequacy in food, clothing, and housing, and their need for services, such as foster care, institutional care, and residential treatment, is secondary. Also, migrants often rely on extended families and close friends or neighbors who frequently care for a child who otherwise might need adoption or foster care services.

The goals of child welfare services to migrant families must first be to provide families with supplemental services such as day care, food supplements, health care, emergency assistance, and education, which will help improve the immediate and future economic and social well being of the migrant child. Meeting these basic needs will have the greatest impact on migrant child welfare. Thus, the services considered in this study are those which affect the areas of physiological and environmental health, education, day care, and child abuse and neglect. The providers of such services include state and federally funded programs, county or district social service and educational agencies, and private programs.

The Nature of the Study

The purposes of this study were:

- To review, assess, and synthesize the literature concerning child welfare services to migrants;
- To determine the nature and extent of child welfare services;
- To determine the number of migrant children receiving those services;
- To determine interactional patterns between existing services and current and former migrant families in need of those services;
- To determine the number needing those services as well as the number receiving them in order to estimate total need;
- To determine the differential need between settled-out migrants and current migrants;
- To determine the differential need between the major streams of migration, as well as the differential need between migrants at home base and in-stream;
- To delineate problem areas that impede service delivery to migrant children without affecting nonmigrant children;
- To determine whether a pattern exists to train migrants to work in services to migrants;
- To explore the feasibility of using alternative funding sources to support welfare services to migrants;
- To analyze the above information in a manner enabling the development of a policy and operation strategy for OCD that will be in the best interest of current and former migrant families.

With the exception of the literature review, the results of which have been published separately, the above items are all closely related. As a consequence, it was necessary to engage in a number of tasks simultaneously. The resultant plan of analysis was sufficiently complex to generate a large body of coordinated information, covering all levels of service provision and need.

In order to obtain the depth of information necessary to describe services to migrants adequately, it was necessary to study selected regions as a nationwide sample. A number of important criteria were met. The final list of states includes major home base as well as user states, regions covering all three streams of migrant activity, states with large numbers of migrants and states with small migrant populations, areas with long-established migrant populations and those in which migrant activity has been more recent, and states with major "settled-out" areas, i.e., former "pass-through" areas in which migrants have established permanent residence. The states selected for this study are the following: California, Colorado, Florida, Iowa, Illinois, Maryland, Michigan, New Jersey, New York, North Carolina, Texas, and Washington. The research was conducted in that county within each state with the largest migrant population; this allowed a thorough analysis of the migrant child welfare situation in areas of largest migrant concentrations.

The study design utilized mail and personal interviews with state and local officials and service providers, interviews with migrant families, and mail questionnaires to training institutions. Each is described briefly below.

Information from state and local officials (including service providers and advocacy organizations) was obtained in two stages. First, mail questionnaires asked primarily for quantitative data such as the number of individuals served by an agency, the number of migrant children served, the total number of migrants in the service area, and the agency's budget. This type of information can be most economically obtained through mail questionnaires, with no loss of accuracy. Second, personal interviews were held with individuals responsible for supplying the information in the mail questionnaires. Those interviews covered policy-related issues, such as funding, and problems in providing services to migrants.

The combined effect of this two-stage interview process was to obtain a balance of quantitative and qualitative information not possible through either mode of contact alone. Individuals interviewed represent the following agencies: state and county public welfare offices, including the protective services division; state and county health departments, as well as migrant health clinics; the state Title I Migrant education office and local educational agencies (LEAs) with Title I programs; and farmworker organizations. Interviews were also conducted with local service providers referred to during other personal interviews, such as local day care centers and voluntary organizations.

In addition to the agency information, information was also obtained from migrant families residing in these same states and counties. Women of the same racial and ethnic backgrounds as the migrants were trained to interview migrant families. Seven hundred and fifty individuals (most often mothers) were questioned regarding their needs and use of child welfare services. The interviews concentrated on several basic areas of child welfare: health care, day care, family services, and education. The respondents were asked their need for these services during the past year (autumn 1975 through autumn 1976). If services had been needed, they were asked whether services had been received when needed; if not, why not. If services had been received, they were asked for their opinions of the services. In addition, several other types of services relating to child welfare were mentioned, including help with family planning, availability of free clothing, and whether free meals were provided by schools. Analysis included separating the responses according to stream (East Coast, mid-continent, and West Coast), and separating current migrants from "settled-outs," i.e., former migrants who have established permanent residence in-stream. These data provide further insight into the delivery of services to migrant families, and, while not a precise "reliability check" on agency information, they do provide perspectives different from that given by agency personnel. Due to the mobility of the migrant population, however, interviewing migrants in even a single state about services received necessarily encompasses services received not only in that location but in other states in which the family had recently travelled as well. As a result, the data obtained from the families in this study reflect services received during the past year, regardless of the location in which they were obtained. It is thus likely that many of the services were needed or received in locations other than those in which agency interviews were conducted; therefore, the family interviews cannot be used to directly support or discount agency data. On the other hand, these data can be useful to agency interpretation of the extent to which the need for child welfare services is being adequately met in the migrant community.

In addition to the above, a separate inquiry was made to institutions that train former migrants to be employed in positions that serve migrants. Approximately 90 training centers were surveyed, including universities and colleges, day care and health care centers, and other established training programs. The aim was to determine whether or not there exists a pattern of training fromer migrants to work with current migrants in service agencies such as health clinics, departments of public welfare, educational institutions, etc. Training individuals who were former migrants to work in these organizations helps alleviate the many problems inherent in serving migrants, such as insensitivity to migrants' problems, lack of bilingual staff, and a lack of knowledge about the migrant situation.

Organization of the Report

The first part of the report will present general "Summaries, Conclusions and Recommendations" based on the topic chapters and site reports. First, a brief summary of the impact of the child welfare services is discussed and an overview of results of the family interviews is presented. Also, a discussion reviewing the organizational structure of program delivery at the state and local levels is provided. These conclusions introduce the general and specific recommendations for each of the areas of migrant child welfare which are the focus of the study.

The data collected in the twelve states and in the household survey will be presented in several ways. The second part of the report "Services to Migrant Children," synthesizes the information obtained from the states according to topic areas of concern to migrant child welfare. These are Public Social Service Agencies, Child Care, Personal and Environmental Health, and Education. Information gathered on each subject or service area is combined topically to provide an overview of that service to migrant children. Each chapter defines the topic and includes a description of federal and state funding sources which are, or can be, utilized to support child welfare efforts in each service area. An assessment of migrant children's needs and the extent to which they are being met is provided, with a description of existing services which address these needs. Program implementation and other factors which affect service delivery, such as administrative structure, support, and coordination of services are reported, as well as barriers of acceptability, availability, and accessibility which impede service delivery.

"Part Three: The Household Survey," is a presentation and discussion of the results of the interviews conducted with migrant families concerning their utilization and need for specific child welfare services. This survey is described above.

Detailed summaries of the findings in each of the twelve states are presented in "Part Four: Analysis of Selected Migrant Farmwork Sites." Each summary describes and discusses the services in each of the topic areas (child care, health, etc.) at state and local levels. The local and county levels are the primary focus, however, because these are the high impact migrant regions in each state, and, therefore, the site visits made by the project staff concentrated on services in these regions.

"Part Five: Issues Concerning Migrant Child Welfare Programs" is composed of three chapters. The first chapter presents two issues: the existence of undocumented workers in the migrant stream, and the need for advocacy of migrant programs. These issues indirectly affect services available and received by migrant families. Also presented in Part Four are the results of the survey concerning training of farmworkers in service to migrants. This is a separate inquiry made to 90 institutions and is described above. The third, and final, chapter consists of two case studies selected to highlight two unique situations. These are the New York State Migrant Day Care Program, representative of the best day care situations, and the migrant living conditions in Immokalee, Florida, representative of the worst living conditions for migrant families.

PART ONE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

CHAPTER I

SUMMARY OF FINDINGS

Social Services

The nature of the information from agencies precludes precise estimation of the number of migrant children served in such programs as in-home service, placement in another home, and institutional placement. These traditional child welfare services have little or no known impact on migrant children. Many agency respondents indicated that, despite lack of data, they were certain that migrants did not receive these services. Many migrants are ineligible for AFDC, and are excluded from programs such as Medicare and Medicaid. The Food Stamps program is the only social services program significantly utilized by migrants. Migrants' access to social services is restricted by their own unfamiliarity with programs in each locale, community attitudes, and lack of transportation. Language barriers and strong family cohesiveness, as well as staff overloads, extensive paperwork and documentation requirements for eligibility combine to minimize the extent of social services utilization of programs with the exception of temporary financial aid.

The social service programs from which most in-stream migrant children can benefit are operated by the states rather than the federal government. Recertification is necessary every time a family crosses a state line, which may happen many times in a year's migration.

Child Care

In the 12 survey states, preschool care was provided to 29,855 young children by the programs in Table I.

TABLE I. Number of Preschool-aged Migrant Children Served by Program or Funding Source

Program/funding source	No. of Preschoolers
ESEA Title I Migrant	17,063
Migrant Head Start	6,000
Title XX, SSA	3,417
State funds	2,150
CETA 303	1,225
TOTAL	29,855

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Title I Migrant Education programs provide day care for younger siblings of school-aged participants, usually using the same school and transportation systems as the older children. With no separate funding for the preschool program, greater costs and stringent licensing requirements threaten the availability of the service. The Migrant Head Start program is the only program for which migrant day care is a priority. The projects use the Head Start curriculum, offer extended hours, hire bilingual/bicultural staff, and provide infant care. Some programs last for less than five months each year and thus cannot readily find qualified full-time staff. Title XX Day Care is offered as a local option, and eligibility requirements and availability of certain services may vary. The incorporation of state funds into the day care network offers opportunities for a consolidated administration, but such consolidation risks jeopardizing the total program if any one of the funding sources is discontinued. The CETA Day Care services are offered to support the manpower training programs, and often consist of purchased slots in existing day care programs.

Most migrant child care programs include a carefully designed curriculum; nutrition programs; health screening, diagnosis, and treatment; parent involvement; extended hours; transportation; and, in some instances, outreach and referrals. However, the programs differ widely in their implementation. The most prevalent problem facing child care programs is in securing facilities which meet licensing requirements. Child care for migrant families is a critical problem everywhere; often, the only alternative is for working parents to take children into the fields.

Education

School related programs were the third most frequently mentioned child rearing problem for migrants. The ESEA Title I Migrant Education Program has the greatest potential impact to improve the education of migrant children, with funds targeted especially for that purpose. Other beneficial funding sources are the basic Title I program, Title VII Bilingual Education, and various state programs. Title I Migrant Education serves approximately 200,000 migrant children in the twelve survey states and an estimated 400,000 nationwide.

Summer programs are the most effective, due to the lack of other programs during the growing season. Academically comparable to those for migrant children during the school year, they are flexible and promote home-school contact for nearly 40,000 migrant children in the survey states. The major drawback of summer programs is that they are operated usually only during normal school hours and are not coordinated with field work hours. Frequently, children are unattended for parts of the day.

Secondary level vocational training under the Title I Migrant Education program reached only 2,500 migrant children, due to the high drop-out rate for secondary level students, the high per pupil cost of such programs, and hesitancy of schools to offer programs for youths who remain in the district for only a short time. The High School Equivalency Program (HEP), currently funded by the Department of Labor, assists approximately 1,000 migrant secondary students each year.

The Title I Migrant Education program addresses the non-academic needs of children as well as providing classroom assistance. Ten states indicated that dental care, sight and hearing remedies, and nutritional supplementation were available; most programs also provided social workers, outreach and recruitment, career counseling, psychological counseling, and accident insurance. In addition to the above services, approximately 40% of the children enrolled in Title I Migrant Education programs receive bilingual/bicultural education in the survey states. About 400,000 migrant children are enrolled in the Migrant Student Record Transfer System (MSRTS), a nationwide education and health records system for migrant students which has two major problems restricting its effectiveness: inadequate recording of base information and inutility of records. Another problem which plagues attempts to educate migrant children is the failure of the Title I Migrant Education office to identify and disseminate information on successful and innovative education techniques. There are also many problems resulting from failure to coordinate at national, state, and local levels.

Health

The most commonly provided health services for migrant children in the twelve survey states include basic health screening, consisting of physical examinations and immunizations (all states); the WIC nutrition program (in nine states); and dental care (in all states). Specialized disease testing and health education are less frequently offered. Children involved in Title I Migrant Education programs are eligible for health diagnosis and treatment. The large number of teenagers out of school and 50,000 to 75,000 migrant preschoolers without day care in the survey states are not covered by these programs. Ineffective record transfer networks may result in over-immunization for some diseases. Although physical examinations and routine screenings are conducted in all states the diseases for which screening is provided and the proportion of migrant children reached vary greatly. Migrants qualify for the WIC nutrition program, but sometimes cannot be accommodated due to limited program size. Health education is one of the most valuable forms of preventive care, but only two of the survey states provide high quality programs. The greater the degree of coordination between health care providers, the more effective the service delivery to migrants.

The Migrant Health Act is the major funding source for health services to migrants. The establishment of Rural Health Initiative to coordinate health services to the rural poor, including migrants, should increase the availability of care for migrants. The proposed revision of the EPSDT program would expand coverage to all medically needy children, without limiting the EPSDT eligibility to those eligible for Medicaid.

The health of migrant children is severely threatened by conditions in the home and in the fields. Housing is inadequate to accommodate large families, is unsanitary, and lacks the basic essentials for a decent living environment. Housing inspections are infrequent, and stricter standards often lead to camp closure rather than improvement of facilities. Available housing is of four types: private rental, employer furnished, family owned, and public rental. All housing for migrants is scarce, however, and migrants frequently live in their vehicles or camp out in fields and along river banks. Access to health services is limited by the rural isolation of much of the existing migrant housing. Migrant parents identified housing as a child-rearing problem more often than any other factor. Children in the fields, working or not, suffer conditions of poor development, exposure to pesticides, and injuries from farm machinery.

CHAPTER II

CONCLUSIONS

Although migrant children and their families benefit from the targeted programs designed to alleviate severe conditions of want, their needs persist unfulfilled. By reviewing the issues which impact upon service delivery to migrants in the context of current government intervention, this chapter presents the basis for the recommendations which follow.

Migrant's characteristics present a test case of the capacity of public agencies to adhere to a policy of equally serving all who need assistance. This policy often becomes translated into agency-centered efforts rather than client-centered efforts. The difference between these two approaches is central to the problem of the nation's social service systems.

Those with special needs--needs greater than normal or needs requiring modification from normal delivery procedures--do not in fact have their needs met equitably compared to others in the population receiving social services. In northern states, migrants seldom are permanent residents of the communities where they must apply for assistance, and therefore the agency cannot use its knowledge of local conditions and resources in effectively addressing their needs.

The local grower pays the going rates for migrant labor and may or may not provide housing. Although migrants are judged by local residents to be living decrepit existences in degrading conditions, it is the local grower who is responsible for the upkeep of the property. The income from the migrant family's labors, often rendered at the end of the work contract, which accrue to them only at the end of their stay in an area, cannot alleviate the conditions. These conditions isolate children and parents from the established communities in which they work and emphasize the barriers preventing their entry to opportunities other than farmwork.

Recommendations to improve the welfare of migrant children must acknowledge the general conditions of migrants in American today. No one issue, such as child welfare, can ignore the tremendous burdens of the migrant. In the present study, one-quarter of the parents who were questioned about problems raising children in the migrant stream cited the lack of money as the most important. All resources--skills, time, education, health care--needed by migrants as well as by all persons, require money. Farmworkers, although harvesters of the nation's food, are blocked by tradition, discrimination, and law from acquiring needed resources to improve their lives. A recent report on the situation of migrants concluded:

> "Farmworkers remain locked in a cycle of poverty and agricultural work guaranteeing the presence of a

substantial number of these workers well into the future. Further, they remain members of a population that is relatively small, and often spurned and ignored despite their direct contribution to the agricultural productivity of the nation." (InterAmerica Research Associates, An Assessment of The Migrant And Seasonal Farmworker Situation In The United States, Volume I, Executive Summary And Conclusions, p. 2)

Uniqueness of Migrant Characteristics

The citation above refers both to farmworkers who migrate and to those for whom travel is not an additional burden. For migrants, however, the constraints of the system under which they work combined with those generated by their own situation amplify the poverty, the inescapable cycle, the exploitation, and the unavailability of legal recourse due to laws exempting farmworkers from rights guaranteed to most other workers in America. Eligibility requirements force them to surmount far greater obstacles than others must to obtain even basic services.

The health consequences of living in migrant camps, when camps, exist, extend beyond the current generation. Enforcing federal standards for farmworker housing without bringing about a mass closure of migrant camps is another problem. This has, in fact, happened in many cases, leading to even more perilous existence for the migrant family in-stream. The problems of reapplying through increasingly complex procedures for social services assistance in each new site visited, have been described, along with their eventual effects of reducing incentive to apply for help even when eligible. The consequences of the lack of child care, when the only alternative is to take the child to the fields, has been presented, noting that conventional, informal child care arrangements (relying on a neighbor or relative) are seldom options available to the migrant family in-stream.

The literature review for this study has further pointed out many cases of protective laws which by provisions exempt migrant farmworkers (Porteous, S. M., Migrant Child Welfare, A Review Of The Literature And Legislation, Washington, D.C.: InterAmerica Research Associates, pp. 60, 64, 70, 134-5). Evidence has been presented that lifestyle, culture, and mobility factors separating the migrant from the non-migrant social services agency applicant operate to exclude the migrant from eligibility for many family services.

The Need for a National Program

As a result of these unique factors and the obstacles to obtaining services, it is clear that pressing needs dictate a priority for continued funding of targeted programs for migrants. Despite some overtures at the state level, most of this programmatic assistance to date has been at the national level. This should continue, but cannot be expected to provide comprehensive benefits for migrants until a coordinated program is developed. In numerous cases, the precedent has been set for clear identification of specific minority groups requiring special consideration. No one agency coordinates federal programs for migrants, so each operates independently and sometimes contrarily to others.

The current trend toward block grants represents one approach to the solution of problems of large-scale government. However, block grants should not be considered an automatic panacea; all programs recognized in need of implementation at the national level should not be subsumed under the block grant funding process. The categorical programs being consolidated do not cover all aspects of the target population's needs. Migrant needs must be addressed comprehensively. In concert, the Migrant Programs in education, health, Head Start, and manpower can cover these needs if properly coordinated. Restructuring of existing programs and coordination among service providers are necessary to approach equitable treatment for migrants.

Clear national policy is necessary if state governments are to develop their own roles in serving migrants. Although targeted services for migrants under a national migrant program might seem to indicate that the federal government has relieved the states of obligations to serve the migrant population, this is not the case. The federal government is emphasizing the needs of migrants, and state and local agencies must improve their own efforts to serve migrant needs in accordance with their obligations to serve all persons equally. Group eligibility for migrants under the Title XX Social Services program is an example; local program coordination should be improved between migrant grantees and other service providers.

The recommendations in Chapter III concern the need for recognition of migrants' special needs interfaced with federal, state, and local program responsibilities. The three Recommendations sections which follow (Policy, Administrative, and Programmatic), take into consideration the complexity of social service provider systems, the need for coordination among them, and the structural alterations necessary for both short-term and long-term change to enable migrant families to achieve full and self-sufficient citizenship.

CHAPTER III

RECOMMENDATIONS

At present, many programs address the needs of migrants, specifically and through general services. This study has addressed programs impacting upon child welfare: social services, child care, education, and health. The recommendations presented here concern the implementation, interaction, and effectiveness of these programs. Also presented are recommendations that go beyond programmatic areas to outline potential avenues for clarifying and optimizing the efficacy of the entire migrant services network.

With approximately $230 million spent annually by the federal government for the direct benefit of migrant farmworkers, the need for federal-level coordination of programs providing these funds is paramount if any of these programs are to maximize their service potential. The fact that they are all directed at a discrete population of more than one million persons necessitates coordination. However, many policy and administrative problems have stood in the way of consolidation or even coordination of these programs. This report addresses this issue as well, in the hopes that today's migrant children will be able to live rewarding lives by the time they reach adulthood.

The recommendations of this report are grouped as follows:

- Policy Recommendations. These concepts, often involving long-term structural change, concern basic improvements in the methods for providing social services to migrant families.
- Administrative Recommendations. Suggestions involving existing programs, their implementation at various levels, and their effectiveness are presented in this section.
- Program Recommendations. Based on findings of this study, a number of specific changes regarding delivery mechanisms and program procedures are presented.

It is hoped that all readers will consider the potentials for change in these contributions and assume appropriate responsibility for their personal and professional part in the improvement of the conditions under which migrant children must now live.

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A. POLICY RECOMMENDATIONS

A.1. Federal Level

A.1.A. System Coordination

A.1.A.1. A federal coordinating panel should be established to ensure that programs targeted for the benefit of migrant farmworkers and their families operate effectively and efficiently. The Community Services Administration (CSA), which currently is responsible for coordinating, reviewing, and monitoring federal programs for migrant and seasonal farmworkers [P.L. 93-644, Sec. 6(b)] is the appropriate organizational location for such a council, although the Office of Human Development in HEW may represent a location which offers greater potential for coordination of programs since most programs for migrants are administered by HEW, none by CSA.

A.1.A.2. Central coordination of federal programs serving migrant farmworkers should be accomplished by a panel comprised of the directors of the federal programs which are designed to serve migrants directly and the directors of programs which include migrants as a substantial portion of their service population. These should include, as minimum representation, the following persons:

- The Assistant Secretary for Human Development, HEW;
- Chief, Policy Development, Title XX Program Office, Public Services Administration, SRS, HEW;
- Chief, Indian and Migrant Programs Division, OCD, HEW;
- Director, Office of Child Development, HEW;
- Chief, Special Programs, Community Services Administration
- Director, Migrant Division, Employment and Training Administration, Department of Labor;
- Director of Rural Development, Department of Agriculture;
- Director, Migrant Task Force, Food and Nutrition Service, Department of Agriculture;
- Director, Migrant Programs Branch, Office of Education, HEW;
- Director, Migrant Health Program, Bureau of Community Health Services, HSA, HEW;
- Assistant Director for Minority Concerns, Domestic Policy Staff, White House.

A.1.A.3. This panel, regardless of location, would be established by authority of the Community Services Administration authorizing legislation of 1977. An Annual Report to the Congress on the migrant and seasonal farmworker situation in the United States would be among its functions. This report would identify basic conditions, impact of programs, improvements in interprogram coordination through the program efforts, and selected issues requiring the further attention of the Congress to improve the effectiveness of the federal government's efforts on behalf of migrant and seasonal farmworkers. One of the first functions of this body would be to develop a standard definition of the term, "migrant," which would thereafter be used in determining eligibility for participation in all migrant programs represented by panel members.

A.1.A.4. This panel, which could be called the Coordinating Council of the Federal Migrant Programs Office (FMPO), would require a support staff to review operations of the member agencies' programs, identify opportunities for improved coordination and effectiveness, and prepare the Annual Report. The Council would have a rotating chairmanship.

A.1.A.5. In conjunction with programmatic changes to foster improved coordination and effectiveness among migrant-targeted projects at the local level, this office would monitor situations in which several migrant-targeted grantees exist in the same locality and are in need of improved coordination. Proof of improvements in coordination would be written into a grantee's application for funding during the next regular funding cycle and would be compared with staff field assessments of local program coordination effectiveness. Improved coordination would be taken into consideration during funding competition.

A.1.A.6. The Federal Regional Council's Task Force on Migrant Farmworkers should prepare for the Coordinating Council of the Federal Migrant Programs Office materials concerning its work to date in assessing and improving the operations of federally funded programs for the benefit of migrant farmworkers, and should become the recognized field arm of the FMPO, through which information could be assembled via conferences, hearings, and assistance provided to local grantees in meeting coordination requirements. Arms of the Task Force should be established in Regional Offices other than Regions II and VI, its current sponsors, to the extent that migrant grantees are located in other areas.

A.1.A.7. The requirements of the FMPO regarding coordination among local grantees should include, as a minimum, proof that a local council of all organizations serving migrant farmworkers and families has been convened and includes private organizations and public agencies; that it meets regularly and as often as needed; and that it has improved coordination of services to migrants through consolidated program planning, pooling of transportation resources, and coordinated outreach worker training and deployment.

A.1.A.8. The definition of a minimum migrant population should be established by the Coordinating Council to assure that migrants' special needs are considered by local providers. One family or two single adult workers per county is suggested as this minimum number; counties having as many or more migrants should reflect this fact in Title XX Needs Assessments and Services Plans.

A.1.A.9. The Federal Regional Council's Task Force on Migrant Farmworkers, as the field arm of the FMPO, should work with state public social services agencies to inform them of, and encourage them to adopt, Title XX Group Eligibility Provisions for migrant families. The Coordinating Council of the FMPO should encourage grantees of the member agencies to assist in this effort also.

A.1.B. Child Care

A.1.B.1. The Title I Migrant Education program should designate preschool child care as a program priority, and revise its entitlement determination procedures so that the number of migrant children, from birth to five years, is reflected in total funding. Not all children may require child care; therefore, it is suggested that the number of preschool-age children served and identified by enrollment on the Migrant Student Record Transfer System be the number of children used in determining such entitlement. Early childhood education is essential to the success of migrant children in later school years. Coordination of programs for preschool and school-aged children results in cost savings through consolidation of resources, and improves educational continuity, while more effectively protecting the child from risk.

A.1.B.2 The 1977 Head Start Program authorization and appropriation bills should provide separate funding through a set-aside for the Migrant Head Start Program. This approach, rather than internal Head Start Bureau allocation, would provide a more secure funding base for the program.

A.1.B.3 The Migrant Head Start program is known to be effective in those few sites in which it operates. The program should be expanded significantly to serve a larger number of children. An evaluation of the program's three experimental models should be undertaken to assist in identifying the types of projects to be supported under this expansion.

A.1.B.4. The Indian and Migrant Programs Division (IMPD), using the resources of the Office of Child Development, should support a training and technical assistance program for migrant child care projects regardless of their funding sources. This administrative support should assist projects in administration, coordination, and utilization of resources, particularly in obtaining Title XX funds and working with licensing and funding organizations to develop procedures which affirm the special needs of migrant children.

A.1.B.5. The Indian and Migrant Programs Division, supported by the Federal Migrant Programs Office, should ensure that all child care facilities serving migrant children suitably meet the special needs of migrant families using their facilities with regard to program duration, hours of operation, availability of transportation, health care services, and outreach. Parent education and involvement should be stressed.

A.1.B.6. The Federal Regional Council Task Force on Migrant Farmworkers should, as the field arm of the FMPO, work with state agencies to ensure that the states assume appropriate responsibility for serving migrants within their boundaries, through coordination of existing federal-and-state sponsored programs and development of new state programs where appropriate. Comprehensive local programs for complete family services should be the goal of such efforts. Creation of state-level offices to coordinate programs for migrants should be urged in states without such offices.

A.1.C. Education

A.1.C.1. The role of the national office of the Title I Migrant Education program should expand to include greater interaction with the State Education Agencies (SEAs) in working to administer programs effectively at the local level. Re-allocation, evaluation, utilization of information systems, and the identification and adaptation of successful models would be included. Emphasis should be placed on integration of programming at the local level with other providers so that in-camp tutoring, parent education, and health education are made available.

A.1.C.2. Congress should require the Title I Migrant Education program in all Local Education Agencies (LEAs) enrolling a set minimum number of eligible migrant children. The Elementary and Secondary Education Act (ESEA) Title VII Bilingual Education program sets the precedent for requiring extra programs in cases where students are denied the right to education because of linguistic and cultural differences.

A.1.D. Health

A.1.D.1. A national health hospitalization insurance program for migrants should be established, based on one of several successful models that have already been tested. All providers of service to migrant children under such a plan would be required to record services on the National Migrant Referral Project, a central migrant health records transfer system, which should be expanded to accommodate a larger national client population.

A.1.D.2. The Women, Infants, and Children (WIC) and Food Stamp programs should be transferred to HEW, where they can be more effectively coordinated with other health and nutritional support programs.

A.2. State Level

A.2.A. Social Services

A.2.A.1. State protective services offices should identify counties having known migrant populations and should work with social service agencies therein to increase the number of families licensed to provide emergency short-term shelter for dependent children who are of the same cultural and linguistic background. Migrant families who have settled-out and are permanent residents of the county are suggested as the most appropriate sponsors for placement of migrant children on an emergency basis. States should have flexible guidelines acknowledging that while settled-out families may be less financially stable than most foster families, the value to the child of the cultural similarity is of greater importance in a short-term placement.

A.3. Local Level

A.3.A. Health

A.3.A.1. In counties where migrant camps are located, county health departments, in conjunction with public housing authorities, should develop procedures for requiring camp owners to notify the county health department if migrants arrive at their camps with children. This could facilitate better coordination and provision of health care to such families and, as a consequence of outreach visits by health workers, serve to censure owners permitting health and safety hazards to persist in their camps.

B. ADMINISTRATIVE RECOMMENDATIONS

B.1. Federal Level

B.1.A. Social Services

B.1.A.1. To alleviate the considerable legal obstacles which arise in protective services cases concerning Mexican and Mexican American families living near the U.S.-Mexico border, OCD should convene a conference on children's welfare similar to that sponsored by the Children's Bureau in 1947, so that arrangements for effective resolution of such cases, especially those concerning illegal aliens, can be adopted by both nations.

B.1.B. Child Care

B.1.B.1. In accordance with any Federal Interagency Day Care Requirements that may be established, the Office of Child Development should incorporate provisions for and assist states in implementing special short-term day care program and licensure procedures that allow for special needs and limited resource requirements. OCD Regional Office personnel should assist in negotiation and assistance efforts. Please also see Recommendation B.2.C.1.

B.1.C. Education

B.1.C.1. The training of bilingual teachers should be emphasized so that there are enough available to run complete bilingual education programs for non- or limited-English speaking migrant children. Please also see Recommendation C.1.B.9.

B.1.C.2. The High School Equivalency Program (HEP) should be transferred from the Department of Labor to the Office of Education, HEW. It should be operated by either the Migrant Branch or the Office of Post-Secondary Education, and be coordinated with the Title I Migrant Education program and secondary-level Learn and Earn programs operated therein, to assure effective interprogram coordination and continuity of services for migrant children. No direct data was gathered on HEP in the present study; an impact evaluation of this program's effectiveness in serving migrant children should be undertaken.

B.1.C.3. The Office of Education should support the inclusion of compensatory programming in the basic educational programs of all schools serving disadvantaged children.

B.1.C.4. The national office of the Title I Migrant Education program should sponsor a longitudinal study of migrant children's language and arithmetic achievement in schools participating in the Title I Migrant Education program.

B.1.C.5. The national office of the Title I Migrant Education program and the SEAs should urge LEAs operating summer migrant programs to increase emphasis on providing educational opportunities to all members of migrant families. Training in parenting, basic education and vocational choices for children should be made available through in-camp programs and evening/week-end activities, and linkages with other providers should be established to facilitate health education and child care training.

B.1.C.6. The Title I Migrant Education program and the ESEA (amended) Title IV-C Dropout Prevention program should coordinate to sponsor development of innovative and meaningful dropout prevention model projects for farmworker youth to improve opportunities for raising traditionally low educational levels of migrant farmworkers and providing training in vocational options available outside and within agriculture.

B.1.C.7. Projects operated by the Migrant Head Start program and the Title I Migrant Education program should be coordinated to offer maximum program efficiency and continuity of care and education in localities served by both and develop plans for improving services to communities where one or both are not supporting a project but eligible migrant children are found. Programs operated by each in the summertime should receive special attention. Please also see Recommendations A.1.B.1, A.1.B.3., and B.1.C.2.

B.1.D. Health

B.1.D.1. Any organization responsible for administration of the WIC program, the MCH program, the EPSDT program, or other federally funded health programs at the local level should inform other local health care providers and the public of their services in an appropriate manner.

B.1.D.2. The WIC program should be available through all grantees of the Migrant Health program. A proportion of the enrollment slots allocated to the grantee should be set aside for use by migrant families in accordance with the number of migrant families who were eligible, regardless of the number actually served, in the previous year.

B.1.D.3. The WIC program office should facilitate the interstate transfer of WIC slots from home base areas serving migrants to in-stream states during those months of the year when enrolled migrant families are often at great nutritional risk while traveling in-stream and cannot continue to benefit from WIC if in-stream slots are already filled.

B.1.D.4. The Bureau of Community Health Services should continue to support training for rural physicians and other health providers serving migrants, in the diagnosis of pesticide poisoning and other medical ailments particularly prevalent among migrants.

B.1.D.5. The Bureau of Community Health Services should support research on the long-term effects of pesticides on farmworkers and others who are exposed.

B.1.D.6. The Bureau of Community Health Services should continue to promote programs which provide financial assistance for the training of health personnel in exchange for agreements to practice, and promote increased use of National Health Service Corps staff in medically underserved rural areas such as those in which migrant health clinics are usually found.

B.1.D.7. The Bureau of Community Health Services should provide training and technical assistance to Migrant Health program grantees in the development and utilization of alternative funding services.

B.2. State Level

B.2.A. System Coordination

B.2.A.1. States with known migrant populations should have offices for the coordination of programs serving their needs. Such offices should convene the heads of all state programs providing services to migrants as a programmatic advisory panel. A corresponding panel representing all local projects receiving funds to serve farmworkers in the state should be established as a service providers advisory panel. The state of California is currently establishing such an office. This office should have authority to approve coordination and policy for the state as carried out by the state programs serving migrants, and should also maintain liaison with the Federal Regional Council Task Force on Migrant Farmworkers and engage in necessary factfinding research concerning the conditions among migrant farmworkers in the state. Please also see Recommendation A.1.B.6.

B.2.B. Social Services

B.2.B.1. State designated Title XX Social Services agencies should allocate a portion of their state administration funds for the provision of training and technical assistance to local nonprofit groups wishing to operate services fundable under Title XX, such as child care and foster care. This local assistance share should support start-up loans and planning grants because many small rural organizations which currently could provide service must first obtain facilities. Please also see Recommendation B.1.B.1.

B.2.B.2. All states should implement procedures under Title XX for emergency care of dependent children to be arranged other than through law enforcement agencies. Hotlines, programs for social services workers on rotating 24-hour call, and agreements with local private day care and foster care facilities to provide emergency shelter care should be arranged so that emergency needs will be met without utilization of police facilities. Police escort may still be necessary during intervention, but case disposition should be a social service function.

B.2.B.3. All Title XX-funded agencies operating in counties having known migrant populations must indicate in their local or regional Title XX Needs Assessments and Services Plans that arrangements have been made to allow for caseworker outreach to migrant camps. This should include logistical and transportation arrangements for periodic visits to the camps in the evenings and on weekends, which are often the only times the families are in the camps and their social services needs can be addressed. The plans may also include arrangements with other agencies for regular one-stop multiple service facilities to be established and staffed at the beginning of the season and regularly thereafter, whereby migrant families can deal with representatives of several different agencies in one facility and comprehensively obtain all needed services. Please also see Recommendations B.3.A.1 and C.2.A.1.

B.2.C. Child Care

B.2.C.1. In areas where community-based short-term migrant day care programs are needed, the appropriate state social services agency should formalize a program for identifying potential sponsors, contacting them in advance of the farmwork season, arranging for funding and licensure, and providing technical assistance in program development, as needed.

B.2.C.2. State social services agencies should coordinate with state-level offices operating the WIC and EPSDT programs to arrange for short-term migrant day care centers to benefit from these programs. Failure to provide program support has limited the number of migrant child care facilities severely. Please also see Recommendations B.1.B.1. and B.2.B.1.

B.2.D. Education

B.2.D.1. State education agencies should incorporate the training of school guidance counselors, located at schools participating in the Title I Migrant Education program, into their state and local program plans. Career education counseling should be emphasized, so that school administrators become attuned to the special needs, characteristics, and potentials of farmworker youth, and assist them in developing career plans and making knowledgeable choices concerning future occupations. Parent training and counseling should be made available for the same purposes. Please also see Recommendations B.1.C.5. and B.1.C.6.

B.2.D.2. The Title I Migrant Education program should continue to support SEA emphasis on the need to provide teacher training in the teaching of migrants. Such training should extend to teacher's aides and other teachers-in-training, and should impact on an entire school faculty, not merely on those persons teaching migrants, as the presence of migrants may affect the entire school atmosphere and should be understood and appropriately utilized.

B.2.E. Health

B.2.E.1. Migrant clinics should provide relevant health education, increased outreach and transportation, and coordination of WIC and EPSDT/CHAP programs to ensure that migrant women and their infants receive needed perinatal care. Coordination with Title I Migrant education projects should be undertaken to facilitate implementation of comprehensive in-camp education programs in parenting, health education, basic adult education, and vocational options. Please also see Recommendation A.1.C.1.

B.3. Local Level

B.3.A. Social Services

B.3.A.1. Grantees of federal programs serving migrants and other local agencies should coordinate outreach to ensure respect for the privacy of the migrant family. Please also see Recommendations A.1.A.5., A.1.A.7., and B.2.B.3.

B.3.A.2. Public Social Service agencies in counties having known migrant populations should be able to provide to migrants, on an emergency basis, blankets, clothing, funds to purchase gasoline and food, as well as being able to refer them to other organizations able to provide emergency help.

B.3.B. Health

B.3.B.1. All migrant health clinics and public health clinics should have outreach to migrant camps and provide transportation. Hours of operation should include evenings and weekends. The Migrant Health program should develop grantee guidelines for reduction of services when funding cutbacks occur so that all transportation and outreach services are not eliminated completely before other components are reduced. Where these services already have been eliminated, steps should be taken to reinstate them.

C. PROGRAMMATIC RECOMMENDATIONS

C.1. Federal Level

C.1.A. Social Services

C.1.A.1. The Food Stamps program should continue to develop procedures for making food stamps more accessible for migrants. Federal regulations should be developed to permit campsites and campfires to be approved as fixed addresses and cooking facilities. Provisions should be made through local social service offices to ensure that migrants can benefit from the program, even when they live in a camp with communal cooking facilities. Policing to ensure that crew leaders are not confiscating the stamps fraudulently or financially exploiting crew members by charging exorbitant prices for meals should be among these procedures. Food Stamp program providers should coordinate with local WIC porgrams, and local agricultural extension nutritional education programs which service the camps, to provide for the nutritional well-being of migrant children and their families.

C.1.A.2. County social services organizations in the counties where federally funded programs serve migrant farmworkers should be required by Food Stamps program regulations to utilize these organizations to assist in the distribution of applications for the program, verification of documentation presented in support of applications, as needed, and prompt submission to the social services agency for approval and granting of assistance. Such agencies should be grantees of the social services agency for the provision of emergency food vouchers. There should be more effective local use of the Food Stamps outreach program. Farmworker organizations should receive additional funds to identify families in the migrant community who need but do not receive food stamps. Please also see Recommendation A.1.A.7.

C.1.B. Education

C.1.B.1. So that children are not left unsupervised in the migrant camps, the Title I Migrant Education program should provide extended day care for migrant children before and after school hours when needed due to the differences between hours of school operation and hours parents must be in the fields at work.

C.1.B.2. The national office of the Title I Migrant Education program should encourage SEAs to develop statewide first-option contracts with migrant health clinics for all LEA project health components.

C.1.B.3. There should be satisfactory improvement in the Migrant Student Record Transfer System (MSRTS) in two years, as determined by objective evaluation, or it should be discontinued and the funds used to improve supportive services for Title I Migrant Education projects. (A benefits assessment was conducted in 1975, but a full evaluation of the program has not been undertaken since its inception.)

C.1.B.4. Current efforts to revise the MSRTS forms to list educational skills by criteria in the form of educational objectives and standardized measures of achievement should be continued and an improved form agreed upon and implemented.

C.1.B.5. Parents' access to their children's MSRTS records should be ensured, while preserving the confidentiality of the records system.

C.1.B.6. Title I Migrant Education summer programs should be permitted to provide funds for contingencies that would be routinely taken care of by the school's normal resources during the school year. Summer projects now cannot obtain services to meet these needs without added cost. A recent situation involving a child in need of advanced psychological testing could not be handled locally; an emergency grant from IMPD was necessary. Contingency funds would have permitted immediate attention.

C.1.B.7. Day care centers that are eligible to receive MSRTS service should not receive lowest priority in obtaining records, as is often the case at present. A subsystem, a parallel system, or an enlarged basic network of terminals should be implemented.

C.1.B.8. The Migrant Student Record Transfer System currently identifies students who may not be enrolled in schools, and home base state directors are informed. A similar technique could examine records for time gaps between entries and could indicate enrollment in which student records were not requested from or added to the system. It could also indicate children who were not enrolled in Title I Migrant Education programs or were out of school during those periods of time. If SEAs were apprised monthly of areas where possible nonenrollments were prevalent, based on presumed line of migration between schools where enrollment was recorded, they could investigate and provide assistance locally for improved enrollment recording, outreach, and recruitment. This would improve the effectiveness of MSRTS and increase the state funding base as well.

C.1.B.9. National and state offices of the Title I Migrant Education program should emphasize bilingual education, especially at the early elementary level, as an important component of programs in LEAs serving migrants of limited English-speaking ability.

C.1.B.10. State Education Agencies should urge LEAs operating Title I Migrant Education projects to participate in the School Breakfast and School Lunch Programs sponsored by the Department of Agriculture. At present, many projects benefit from these programs, but some projects provide only lunch.

C.1.B.11. SEAs in all states receiving Title I Migrant Education program funds should assess the ability of their migrant offices to coordinate migrant program objectives with other objectives in their agencies, specifically compensatory education and the overall state educational objectives. These migrant offices should support and attempt to replicate successful models for improving interstate-level coordination now being developed by the Education Commission of the States under its Interstate Migrant Education Project.

C.1.C. Health

C.1.C.1. Health and nutrition education components should be a part of the programs of migrant health clinics. This can be done through showing films and holding discussions in waiting rooms at the clinics. Outreach workers should be trained also to identify and address home situations needing follow-up, and where possible, comprehensive programs using mobile classrooms and trained aides should be implemented.

C.1.C.2. The Migrant Hospitalization program should be expanded until a suitable alternative nationwide migrant health insurance program or a comprehensive or national health insurance program has been implemented. At present, this program is limited, and even in concert with other experimental health coverage programs, no method of providing migrants with coverage in the event of hospitalization exists comprehensively.

C.1.C.3. Child care centers serving migrants, and funded by federal or state programs for that purpose, should be required to arrange for health care for their children through available migrant health clinics before turning to other potential sources. The Migrant Health program office should be involved in facilitating such linkages and should develop regulations to do so.

C.2. State Level

C.2.A. Social Services

C.2.A.1. In counties having known migrant populations, Needs Assessments prepared in the Title XX planning process should include such information as the identification of local migrant working hours and whether local social services program intake accommodates the assessment of the need for migrant child care, condition of local migrant housing and environs, and steps taken to provide protective services outreach to this population. Please also see Recommendations B.2.B.3. and C.3.A.1.

C.2.B. Education

C.2.B.1. The Title I Migrant Education program at national, state and local levels should work to ensure that outreach, identification, and recruitment workers on all Title I Migrant Education projects are cognizant of all other service programs for migrant families in their vicinity, and can provide information when needed. Such information should include, in addition to the name and location of the provider, necessary instruction regarding procedures and forms required, hours of operation, and potential obstacles to eligibility. Please also see Recommendations A.1.A.7. and B.3.A.1. This outreach should be coordinated with comprehensive in-camp services programs for family education and counseling. Please also see Recommendation B.2.E.1.

C.3. Local Level

C.3.A. Social Services

C.3.A.1. In counties having known migrant populations, the county social services agency, as indicated in its Title XX Social Services Plan, should make available to all local programs serving migrants the names of caseworkers responsible for protective services case disposition, should such cases arise in migrant camps. Caseworkers should participate with the migrant organizations in conferences concerning the characteristics of migrant families and appropriate techniques for performing protective services. Please also see Recommendations A.1.A.7., B.2.B.2., and C.2.A.1.

C.3.B. Health

C.3.B.1. When assisting migrant clients, intake staff at public and migrant health clinics should consider environmental circumstances, such as limited availability of refrigeration, overcrowded housing, pesticide storage and usage dangers, and general migrant camp health and safety hazards, so that opportunities for preventive health care, education, and proper identification of personal health symptoms not common in the local resident community are maximized.

C.3.B.2. In counties having known migrant populations, public health clinics should attempt to provide on their intake staff personnel of the same cultural and linguistic backgrounds as the migrant clients.

PART TWO

SERVICES TO MIGRANT CHILDREN

CHAPTER I

PUBLIC SOCIAL SERVICE AGENCIES

This chapter explores those services which contribute to child welfare and examines the traditional child welfare programs and related general assistance programs which can contribute to migrant child welfare. Government welfare agencies are the primary providers of such programs, although private providers address these needs as well. The primary orientation here will be a review of the operations of the state and local agencies. For each state studied, the state agency designated as the provider of services under the Title XX Social Services program and the local level service providers thereof were surveyed to determine their effectiveness in serving migrant children.

The chapter reviews the services under consideration and their application to the migrant population, and assesses their actual implementation by the agencies studied. This includes a discussion of each service and an analysis of administrative factors which affect service delivery. State level coordination and program support at the federal level are described. User perceptions, gathered from migrant family interviews, are analyzed. Finally, conclusions regarding the present status and future potential of public social services for migrant children are presented.

It should be noted that no state social services agency surveyed identifies migrants as such on case records. This seriously hampered data collection. In preparing this review of services, user comments, indirect measures, and anecdotal evidence have been utilized, as well as any local level records which were available. The lack of state level data by type of service to a large extent prohibits definitive statements concerning the provision of social services to migrants. In a few locations, it was indicated that migrants definitely did not receive some services. In most cases, they were served along with others in the general population, but to an unknown extent.

Services Under Study

Four types of services which have an impact on migrant children will be reviewed. The first three types of social service programs of interest here are those conventionally regarded as child welfare services: in-home care, placement in another home, and placement in an institution. The fourth category of programs examined is related general assistance--such as the Food Stamps program and Aid to Families with Dependent Children (AFDC)--from which important child welfare benefits derive.

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The conventional programs are based on three functional areas of child welfare: prevention, which involves services of either an emergency or long-term nature to help the family remain together; supplementation, which refers to services designed to augment the family's resources temporarily; and substitution, which refers to alternative living arrangements for a child outside of his own family's home. These components of child welfare can also be considered in terms of the specific activities they involve. Prevention involves emergency shelter care or longer-term counseling; supplementation often refers to making child care arrangements available to the family and includes such in-home services as homemaker and home management assistance; and substitution refers to placement of the child in an adoptive home, a foster home, a group home, or an institution such as a publicly run residential youth facility or detention center.

These services can therefore be grouped in terms of whether they involve in-home service, placement in another home, or placement in an institution. This grouping permits clearer analysis of services to migrants, as specific agency activities can be discussed.

In-home Service

Only two instances of in-home service for migrant families in the sample states in 1975-76 were identified, both in New Jersey. Periodic home visits by a counseling caseworker, homemaker, or babysitter through arrangement with the local welfare agency seldom occurred. Migrants usually find help through family and friends, and are unlikely to bring the need for services into discussion when applying for other forms of assistance. Also, migrants are typically in a work area too briefly for arrangements to be made and/or they know that such assistance is not practical when they live in camps with communal cooking facilities.

Placement In Another Home

Only rarely did social service agencies report the placement of migrant children in another home, although it should be noted that these agencies in general did not know whether such services went to migrants. The period of time necessary for processing of long-term placements often precludes migrant participation, unless children are already under the care of public agencies, living in institutions, or temporarily placed in a foster home. Such short-term placements usually occur as the result of some precipitating incident in the home that brings about agency intervention, and such an incident in a migrant home is unlikely to gain agency attention. Those incidents requiring intervention often result in a disposition other than permanent placement. Several agencies reported that their procedures for serving dependent migrant children involved attempting to contact relatives in the child's home base area, and paying the costs of transporting the child home. The inception of the Interstate Compact on the Placement of Children may bring about more effective processing of placement for dependent migrant children, especially those who become at risk while in the migrant stream. In two states, it was indicated by knowledgeable program staff that no migrant children were in foster homes in the county under study; one of these respondents indicated that none of the homes would consent to accept migrants or Mexican American children.

Institutional Placement

Little data on placement of children in institutions are available for this report, due to the combination of the unavailability of data from social service agency staff on migrants served and the fact that many institutional placements, particularly short-term care, grow out of police interventions rather than through social services. One social services agency respondent indicated that it was difficult to obtain information from the local law enforcement agency regarding whether any children were in the local emergency shelter facility (part of the county detention center for youthful offenders), much less whether the children were from migrant families. Several social service agency respondents indicated that the agency generally had no knowledge of police action involving migrant children until long after the child and his/her family had left. Thus, many of the services traditionally regarded as child welfare services have little or no known impact on migrant children.

Family Assistance Programs

The last category of service to be considered in this chapter concerns general family assistance programs such as Aid to Families with Dependent Children (AFDC) and the Food Stamp program. These programs, along with Title XX Social Services, have significant consequence to child welfare in the migrant population. As discussed in the Review of the Literature and Legislation, and confirmed by the field work for this study, many migrants are not eligible for AFDC (Porteous, S. M., Migrant Child Welfare, A Review of the Literature and Legislation, pp. 33-34). Thus, they can not benefit from other programs which require AFDC eligibility as a criterion for participation. Many states, for example, base Medicare and Medicaid eligibility on AFDC eligibility. The Food Stamps program, on the other hand, is widely utilized by migrants both in their travels and in home base areas. It can provide short-term assistance to families with little money--a common situation among migrants in-stream--and it also has provisions for emergency aid.

There are inevitably differences in degree of services utilization between the home base and in-stream populations, due to the day-to-day requirements of the in-stream family that make complex utilization of agency programs impossible. Migrancy is not a permanent state, and those families who have settled-out may encounter fewer obstacles to receiving services than do current migrants, either at home base or in-stream. The following section focuses on the nature of such obstacles.

A number of factors hinder migrants in obtaining social services as readily as the rest of the population. These factors concern the nature of the communities in which migrants typically are found, the high degree of mobility of the migrants themselves, and the nature of the agencies through which services are to be obtained.

Nature Of The Community

The communities to which farmworkers migrate are rural, small, and supported primarily by agriculture. Such communities are traditionally conservative with regard to government expenditures in general and social programs in particular, and further tend to be relatively more racially and ethnically homogeneous than larger population centers that have a greater occupational mix and a more diverse economy. In all but two of the states surveyed, the county government plays a role in planning for and administering local social services. As a result, elected officials represent the views held by the community, and program planners must provide services that are in accordance with local, state, and federal social services objectives.

Due to the dominant role of agriculture in the local economies, the owners of agricultural enterprises tend to be well represented in the local government and political leadership. The use of migratory labor is typically well known as are the amount of their wages, the typical housing used by migrants, and their cultural and language distinctions. Agency involvement in comprehensive social services to migrants, including regular outreach visits to the camps (which are usually on a grower's property), may be considered interference with a grower's affairs. If a grower is generally opposed to government social programs, he may find convenient, informal ways through the local decision-making process to minimize such services, such as pointing out the duty of the agency to focus on unmet needs among the year-round, resident population.

The migrant camp setting itself impedes service delivery. Migrants frequently travel in crews, arriving in an area by prior arrangement just at the time their services are needed and leaving shortly thereafter, spending all their time either in the camp or in the fields. Not all members of such a group may have ready access to transportation. Some crew leaders control the activities of their employees by using permission to visit a social service agency as a reward, and denying such permission as a punishment or reprimand. Growers themselves may strictly prohibit access to their lands and/ or their migrant camps by social program representatives. Finally, migrants in the area for only a short time usually do not know of agencies and programs to which they could turn for assistance.

Characteristics of Migrants

The nature of the migrant population itself creates obstacles to service. Almost two-thirds of the migrants in this country are of Hispanic origin, including Puerto Ricans, Mexican Americans, and legally or illegally entered Mexicans. Of these, a large portion have only a minimal knowledge of the English language. Negotiation of agency intake and application procedures are formidable tasks when they must be carried out between an agent and a migrant who share neither language nor culture. Private social service organizations, such as those operating federally sponsored migrant manpower and health programs, provide bilingual staff members to assist the applicant if possible, and there is a small but growing number of public agencies which recognize and meet the need for interpreters. If local farmworker organizations do not provide language assistance, and if the local agency's non-migrant clientele is almost exclusively English-speaking, the agency's services are effectively unavailable to migrants of limited English-speaking ability.

Cultural factors, which are intertwined with linguistic differences from the host community, affect both the types of services that could be provided and the migrant's ability to obtain them. In the Hispanic migrant population, which for the most part consists of families traveling together, a strong sense of family self-sufficiency and responsibility predominates. As a result, situations requiring alterations of the structure of the household or temporary removal of some of its members tend to be resolved internally, using the family's own resources rather than seeking or permitting outside aid. Several agency respondents indicated that attempts at intervention (which, in many states, require police as well as social services action) by social services agency representatives characteristically would be cause for a family to migrate onward, prior to their planned time of departure; in one case an entire crew left, leaving the grower without workers, when it was discovered that a nocturnal police visit was brought about by an inaccurate report of child abuse.

Migrant families, unlike other needy families, are away from their permanent homes and lead more tenuous lives. A car accident can leave a family stranded in a strange state with no money left after repairs, if there is enough money for repairs in the first place. Changes in weather or the discovery that there is no housing at a work site, necessitating sleeping out-of-doors or in a car, may create greater risks of exposure than anticipated. The family may simply have to spend their last money on food and have none for gasoline to enable them to drive to a place where they know there will be work. Social service agencies are in general not prepared to deal with such situations other than through what may be inapplicable programs--a family without blankets cannot be helped with food stamps. Private groups, such as farmworker organizations or church-related volunteer service organizations, are generally the only resources available to address these needs, but typically can provide only limited assistance.

Social Service Agencies

The typical administrative and applicant processing procedures of county social service providers reflect known obstacles to social services delivery in any setting, not just in areas populated by migrants. Perhaps the most outstanding characteristic of such agencies is caseloads well beyond the capabilities of available staff and resources. Such overloads often make outreach impossible and any applicant receives more limited attention than might be required. De facto constraints exist aside from policy decisions.

The increased paperwork burden on eligibility case-workers under the Title XX program means that the intake interview often becomes more difficult. The perception that the applicant is soliciting the state's assistance, rather than asserting his/her rights under law, becomes magnified. Many migrant respondents have indicated the personal difficulty of requesting such aid.

The preparation of forms in many cases in which a state or county agency uses a consolidated form for all of its services can become onerous for even relatively minor services. In New York, a migrant mother wishing to enroll her several children in the state migrant day care program when it was under Title XX had to complete a six page application form for each child, usually possible only with assistance from a local advocacy organization outreach worker. In Washington state, one standard form is used for all services including emergency food vouchers, which are usually only requested when a family is totally without resources. The form is nineteen pages long. It has been appended to this chapter in illustration of the difficulty of the application process, especially for a non-English speaking migrant parent prepared with an eighth grade education. This form, even with the assistance of an outreach worker or the eligibility worker, often takes a full day to complete. Another day is then required to verify the information on the form, a third for internal processing of the assistance to be awarded, and on the fourth, a check, food vouchers, or other help can be provided to the family. A typical caseload backup of two days exists, however, so the actual time required to obtain even emergency food vouchers is six working days from initial contact with the agency.

In addition to the length of the application forms, information required to prove need and certify elegibility is often difficult for the migrant applicant to provide. Pay stubs itemizing work performed, period, pay rate, and deductions are frequently not provided when migrants are paid for their work, and few migrants carry such items as birth certificates, which some states require as proof of citizenships and/or relationship prior to awarding aid.

In some cases, processing of assistance may be held up, as with food stamps, when the family cannot provide a "fixed address." Migrant families confronted with a lack of housing must sleep in the fields, beside the road, along riverbanks, or sometimes, in their cars. Many migrants, in areas that have brief harvesting seasons, may have finished their work and moved on before their application forms have been processed. And, in each new locale, the family must repeat the entire application process in order to request aid.

Criteria Of Appropriateness

The factors cited above constitute strong barriers to service, even of the most temporary kind, by established public agencies. For more long-term forms of assistance, such as those conventionally thought of as child welfare services, very few migrants are served. Migrants and agency personnel both acknowledge this fact; migrants may prefer their own intra- and interfamilial resources in addressing such problems, and agencies may prefer to concentrate on the local, year-round resident population. Unfortunately, this lack of contact makes it difficult to ascertain if migrant child welfare services, both formal and informal, are being provided. Some agency respondents indicated that conventional child welfare services, such as foster care, adoption, and, to some extent, protective services which their agency provided, were inappropriate for the migrant populations in their areas. Within the current system, this may be true. An overview assessment of services in terms of various criteria of appropriateness may illustrate this:

- Accessibility--Although there were public service agencies in all areas visited, the rural settings necessitated access to transportation, which many migrants do not have and agencies generally do not provide.

- Availability--Agencies may refer migrants to local farmworker organizations rather than making their own publicly supported resources available.

- Acceptability--Documentation, delay, complexity, and caseworker attitudes, discussed above, often deter migrant families even from seeking assistance from public social service agencies.

- Flexibility--Few agencies provide direct outreach. Only two had standing arrangements to permit caseworkers to visit migrant camps in the evening, when migrants are not in the fields, although many agencies contracted with farmworker organizations for food stamps outreach.

- Continuity--Migrants must generally reapply for assistance in each locale they visit. Migrant families seldom receive agency assistance in protective services cases; when they do, although agencies may be willing to forward records and to contact the next providers, families may not inform the agencies as to times of departure and destinations.

- Utilization--As a result of these factors, migrants seldom use public social service agencies other than for temporary financial assistance.

The following section provides insight into the operations of agencies contacted with regard to specific programs from which migrants may benefit, and illustrates further how encounters between agencies and migrant applicants often are unproductive.

Provision Of Services

Child Welfare Services

The benefits of programs to migrants are varied. The following discussions point out the consequences of specific child welfare programs for the migrant children they serve.

Migrants are perceived as having a cohesive family system and thus having less need for protective services in general than do other groups. Further, when family situations require that the family be relieved of the care of a child, it is common to have a member of the extended family, or the migrant community, take the child in for as long as needed, without involving social service agencies. As a result, almost no evidence of foster care placement or adoption of migrant children was found. The patterns outlined above, in fact, were clearly those considered by several social services agency respondents in this study who said that their family services were inappropriate for the migrant population.

From results of this study, it can be concluded that social service agencies almost never involve migrant families in alternative placement services. No survey state identified migrants in records of services provided to their social services population. Thus, it is not possible to support or refute opinions expressed by agency respondents. They did indicate that migrants did not remain in their regions long enough to complete the required proceedings for child placement. (As mentioned above, the Interstate Compact on the Placement of Children may have a positive impact on this problem.) Other respondents indicated that migrants were not served because they were transients, or because intervention might cause a family to leave the area. Caseworkers indicated that visits to migrant camps were rarely made, so identification of potential protective services situations was unperformable.

In-home services are usually provided when one or both parents are incapacitated and assistance and/or counseling is required, or in cases of neglect in the operation of the household, to help preserve the family unit. Such services are usually offered by social services agencies in the form of caseworker visits, psychological counseling, and homemaker assignments. The migrating family is so isolated by both culture and lifestyle from the public agencies providing these services that they seldom can be served adequately. Only two incidents of migrant families receiving in-home services were identified from a twelve-county national sample of service providers, covering approximately 100,000 migrant farmworkers or 20,000 migrant families.

The constraints on services to migrants discussed thus far is presented in much greater detail in the chapters of this report dealing with each locale studied (please see Part Four). The simple conclusion is that, while a few special programs exist and some public agencies do knowingly seek out and serve migrants, acknowledging their special circumstances, migrants as a group do not benefit from existing conventional child welfare programs.

General Assistance Programs

A number of other programs, often administered by the same agencies which provide child welfare services, also serve some of the same objectives. Unemployment insurance, for example, can aid eligible migrant workers during the winter months, although some families are marginally able to live off their previous year's earnings. AFDC and its related programs, and the Food Stamps program, are discussed below to illustrate the extent to which they are available to migrants, and to indicate the barriers that often arise in obtaining those services.

AFDC And Related Programs - It is almost impossible for migrating farmworkers to obtain assistance under the AFDC program. Major hindrances to service are the lack of a fixed address and the mobile worklife which takes them away from an area before assistance applications can be processed. In addition, few state agencies administering AFDC will provide aid to a family they know to be a permanent resident of another state. A migrant's home state cannot pay benefits if a person is out of state for four to six months of the year, so a family cannot utilize the program even if they meet other eligibility requirements. Even in the home base states, many do not qualify, as most migrating families have two parents, and AFDC is designed primarily for one-parent families.

If migrants do not qualify for AFDC benefits, they are similarly not eligible for other programs that are adjunct to AFDC, such as the entire federal Medicaid program and its Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children. While those migrant children who obtain placement in day care centers usually receive some form of health care, many children do not. At present, with state administration of the Medicare and Medicaid programs, eligibility does not extend across state lines. Some thirty-five states participate in a federal program to provide medical assistance to the medically indigent, and it is this program to which migrant health clinics must often turn. Several of those surveyed indicated that the funds in this program still fall far short of the need, and usually are exhausted each year only halfway through the migrant season. (Please refer to Part Two, Chapter IV of this report for a more extensive discussion of health services for migrants.)

Food Stamps - The Food Stamps program, which does not have residence or single-parent requirements, is more accessible to migrant families and is often utilized by the families during the migrant work season. Procedures and constraints that constitute serious barriers to migrants' ability to utilize the Food Stamps program persist despite several efforts by the Department of Agriculture to improve Food Stamps services to migrants. These barriers, and efforts to overcome them, are described in the Review of the Literature for this project (Porteous, S.M., Migrant Child Welfare, pp. 18-25); and in a recent USDA report as well (U.S. Department of Agriculture, USDA Reports on the Migrant Farmworker: America's Forgotten Farmer, pp. 23-45). Field work performed in the course of this study confirmed the existence of these obstacles. Briefly, they include the need for documentation of income and assets; an orientation toward nonmigrant, permanent residents of an area despite modifications to help migrants; restrictions on what can be purchased; and the requirement that the family have a fixed address and cooking facilities. (Migrants unable to locate housing often must camp out; the campsite and campfire may or may not be found satisfactory as "address" and "cooking facilities" by the local eligibility caseworker.)

These cases illustrate the difficulty migrants have in benefitting from general assistance programs for which they have need and are eligible. As was shown previously, child welfare services also are often unavailable for migrants. The following section discusses some of the issues responsible for these barriers.

Characteristics Of Agencies Serving Migrants

Migrants, like other members of American society, have concerns about accepting outside assistance from any source. Of the 750 families interviewed for this study, more than 55% of the respondents expressed negative attitudes about turning to their friends or neighbors for assistance, 46% were opposed to going to the welfare agency. Thus, the acceptability of social services may be limited through factors beyond the control of the agency providing such services. However, migrants find such services less acceptable than do other groups for reasons stated above, and the reluctance to seek help only adds to the problems of access and agency flexibility. Prior experiences with negative caseworker attitudes may contribute to the formation of such reluctance. In Texas, a welfare agency respondent acknowledged that perhaps there should be a staff development program operated by the agency for its caseworkers, so that their attitudes toward the applicants could be improved.

In Washington state, welfare agency respondents indicated that an audit of accounts has been underway since 1975, under which the past files of those applying for assistance are checked at the time of application. If an audit reveals evidence of previous overpayment, then a deduction is made from the current amount to be awarded, even if an overpayment was the error of agency staff. Thus, many migrants are hesitant even to apply for aid as the repayment may be larger than the amount of aid for which they qualify.

As of October 1976, state Title XX programs are authorized by P. L. 94-401 to declare migrants eligible as a group for Title XX social services, waiving the need for individual eligibility determination with its lengthy and difficult application and documentation procedures. States considering the adoption of this plan are not expected to do so before formally implementing their 1978 Comprehensive Annual Services Plan. While the states' intent is unknown, adoption by a significant number of those states in which migrants travel would do much to ease the eligibility barriers to migrants in their efforts to obtain services. However, overall consequences for migrant child care, local social services for migrants, and the proportion of local Title XX funds that would be used for child care expenses cannot be extrapolated at this time.

The social services agencies visited in this study lack the flexibility to tailor resources to meet special needs and thereby to provide equal services to all regardless of their situation. Caseworkers visit migrant camps only out of personal initiative, as nowhere were such visits normal agency procedure. There were reports of difficulties in arranging for compensatory-time whereby caseworkers could visit the camps in the evening so that migrants would not have to forfeit wages to visit the welfare office.

Outside of Texas, there were a total of only seven former migrants employed in four offices of the fifteen local social services agencies surveyed and approximately thirty bilingual persons were employed by such agencies; but there were regions without bilingual staff where more than fifty percent of the social services population were known to be Spanish-speaking. One agency respondent believed that ninety percent of this migrant population spoke English, so interpreting skills were not needed. Staff members who have been migrants themselves can bring sensitivity to agency services, particularly through outreach work, and can help an agency to improve services to migrants. Bilingual persons who qualify for the Civil Service hiring requirements with which most agencies must comply may not be widely available, however.

Flexibility in services is not necessarily a priority of local social services offices, but is a consideration in the Title XX planning process. This process, including both community input and formal agency needs assessments prior to submission of the proposed plan to the state, provides vehicles for program adaptation to meet the migrants' needs more effectively in those areas of a state with significant, perennial migrant populations. Most of the counties visited in the course of this study fall into this category, and at least one includes migrants in its demographic introduction to its 1976-77 Title XX plan (although they are not mentioned elsewhere, such as under the description of services to be offered). Only three social service agencies in survey counties have outreach to assist migrants in obtaining services. One agency helps to sponsor a volunteer group, and the other two utilize agency staff. None of the three provide comprehensive service, only outreach and referral.

The basic social services problem for migrants is the inflexibility of the agencies from which they must request services. These agencies often permit special arrangements with farmworker organizations and other advocacy groups to facilitate application preparation and processing forms for the Food Stamps program. This service was available in counties visited in ten of the twelve states studied. However, this program by itself falls far short of a comprehensive review of a family's situation by a social services caseworker who is aware of the resources of the social services agency that can be brought to bear in assisting a family, the sort of contact that rarely occurs.

None of the programs from which in-stream migrant children can benefit are directly federally operated. In each new locale, recertification for services must be established. This is a time consuming process fraught with obstacles to obtaining assistance, and is the primary barrier to continuity of services for the migrant family. In the case of protective services, there is a greater stress placed on continuity of services by social services agencies. The typical response from agencies asked about arrangements for continuity was that, if the family in question was known to be migrant and if the family indicated to the agency the date of departure and specific destination, the agency would forward case records to the local protective services agency in the next area. The majority of agency respondents indicated that they were willing to provide such services to assure continuity, but that the necessary information was generally lacking. A few agencies indicated that if they discovered that a family already had left the area, and could discover from other sources even to what state they had gone, they would follow through by contacting that state's protective services office, or those in all likely states. This is not an effective method of maintaining appropriate safeguards for the children, and services for the adults, in child abuse and neglect situations. The recent creation of the Texas Migrant Council's Child Abuse and Neglect Prevention program has made continuous care a possibility for migrants in some states, however. This program still relies to some extent on the cooperation of the in-stream state's protective services network with which the family may never come in contact. Otherwise, ability to monitor a family's movements are limited.

Two information systems, the Migrant Student Record Transfer System (MSRTS) and the National Migrant Health Referral Project (NMHRP), attempt to meet the needs for continuity by maintaining information on individual migrant children's educational and health situations (MSRTS), and health information plus identification of potential local health service providers in destination areas (NMHRP).

State and Federal Involvement

The State Role

Of the twelve states included in this survey, only one reported that members of the migrant population are identified as such on case records in the state public welfare and social services agency information network. In that state, however, the information was not useable for planning or needs assessment purposes as identification was not tied to the specific services migrant clients were receiving. No other state, including the home base state of Texas--the residence of almost four hundred thousand migrants each winter--knows which clients derive their income, and encounter many of their problems in migratory agricultural work. As a result, none of the state social services agencies could provide information on the welfare of migrant families in their states, seriously hampering data collection efforts. Many such respondents, however, did know from their own prior local level experience something of the conditions under which migrants lived at that time; such information could only be noted as anecdotal and not generalizable to current conditions or even statewide conditions. In Maryland, a social services agency respondent indicated that, in order for migrant child care to become a line item in the Maryland Title XX Comprehensive Annual Services Plan, a needs assessment must be conducted to determine if services to this group were sufficiently lacking to justify establishing a new Title XX priority for addressing those needs. In order to conduct such a needs assessment, however, would involve asking the local social services agencies to begin recording and reporting on services to migrants. Only an executive-level decision in the state social services agency can authorize this data collection, and such a decision would not be made unless services to the group on whom data is to be collected had already been declared a departmental priority--a bureaucratic "Catch-22."

Based largely on anecdotal evidence, it was determined in three of the survey states that the state social services agency protective services unit knew that there had been protective services cases in 1976 involving migrant children, although the case records did not provide this information. Special protective services problems of migrants, such as seeing that necessary records are forwarded by local agencies when the family moves on, were not being addressed directly by any of the state social service agency protective services units queried, although three states indicated linkages with the Texas Migrant Council, which assists in providing protective services care to migrants in-stream.

As mentioned above in this chapter, a federal provision has existed since late 1976 permitting states to declare migrants eligible for Title XX services based solely on their status as migrants, without individual income eligibility examinations. When the data was collected for this study, which was near the time that the provision was enacted, no state had implemented such a plan.

Illinois and Michigan, however, have migrant offices within their social services agencies to facilitate services to migrants. Respondents in Michigan indicated a clear intention to take the necessary steps to include migrant group eligibility as a part of the 1977-78 Title XX Comprehensive Annual Service Plan (to be prepared by mid-1977).

In four states, it was reported that Title XX was known not to be used for migrant farmworkers on a targeted basis. At least one of these states did operate a program for migrants but avoided using Title XX funding for the program in order to escape the reporting and programmatic requirements it imposes. Five of the twelve states did not operate any special social services programs serving migrants, although at least one of those states did work with the Texas Migrant Council's Child Abuse and Neglect project. The other seven states all funded some form of day care service for migrant children, ranging from two states each with only one center for migrant children supported by the state, to two states with complete statewide migrant day care programs; in California, the program exists as an adjunct to a statewide state-sponsored migrant camp program.

Based on: (a) assessments of the size and comprehensiveness of the state's programs serving migrant families in comparison to the number of migrant families known to be in the state each year, (b) the existence and use of inter-agency linkages that permit coordination of programs sponsored by different agencies at the local level, and (c) the apparent state of knowledge and concern on the part of state agency personnel of the characteristics and conditions of migrant farmworkers in the state, the overall effectiveness of the coordination among state level agencies serving migrant families was considered to be good in two states. Eight were considered fair or less than adequate. Two states (Florida and New Jersey) had noticeably poor coordination of state level programs serving migrants.

In seven of the twelve states, social services programs were available at the local level through branch offices of a state agency. In four of the other five cases, such services were obtainable through county-run agencies; in the other state (New Jersey), branch offices of the state agency and county-run offices both provided programs. The field work data indicated that locally run programs tended to have more local input into their operation, prioritization of service categories, and degree of flexibility in tailoring operations to local needs. However, the result seemed to be a greater intransigence with regard to serving migrants. While state-run service providers indicated that statewide agency regulations prohibited them from operating programs tailored to local needs, local-run program personnel tended to feel that local needs were being met, although with either source, migrants were substantially not being served.

In preparing Title XX plans, the states with locally run social services agencies appeared to have more leeway in developing complete plans based on local information gathering and community response. Local input was normally transmitted to the state level for approval and inclusion as a component of the state Title XX plan. In states having state-run local social service agencies, draft plans would be drawn up at the regional level, forwarded to the state office, and used piecemeal in the development of one overall state plan which likely would show little local level flexibility.

With the 1977-78 plans, the Title XX planning and program development process is, however, only entering its third year of operation. Both state and local needs assessment techniques to assure appropriate service and efficient local planning can be expected to improve. One state noted in its proposed 1977-78 plan that several staff members undertaking organized needs assessments for the first time in the preparation of the plan components were surprised to find so many other local service providers with whom they could initiate cooperation to improve efficiency.

Federal Involvement

The federal government is involved in social services which have an impact upon migrant families through three primary funding routes. Block grants provide funds for many kinds of state social services programs with relatively few constraints on the allocation of these funds other than program criteria and general guidelines for eligibility determination. Second, categorical social service programs are designed at the federal level and administered by the social services agencies at the state level in line with federally determined eligibility criteria. The third are targeted programs designed to serve a specific need of a population group and administered by either state or local public organizations or private grantees. Titles IV-B, services to children; XIX, health services to the poor and aged; and XX, social services of the Social Security Act, are block grant programs. Aid to Families with Dependent Children and the Food Stamps program are examples of categorical programs. The Migrant Health program, the Migrant Head Start program, and the Texas Migrant Council Child Abuse and Neglect project are examples of targeted programs. Each of these programs, and the services it provides, are discussed in greater detail in the literature review to this study (Porteous, S.M., Migrant Child Welfare pp. 14, 118, 133).

In assessing the efficacy of each of these methods, field data collection revealed information which may have consequences useful in the development of more effective programs for improving the welfare of migrant children. The block grant approach, for example, allows considerable state and local discretion in determining services to be provided. Respondents at the state level were asked whether services for migrant children could, practically speaking, ever become a line item, or statewide component, of their state's Title XX programs. They unanimously answered in the negative, citing the lack of political representation and influence of the migrant farmworker population, the small numbers of migrants compared to other groups desiring categorical services, and the pressures from recipients of other Title XX services if their allocations were cut in order to begin serving a new population under a fixed funding ceiling. Congressional action in permitting states to grant group eligibility to migrants for Title XX social services mitigates the situation somewhat, if adopted by states with significant migrant populations. Many migrants already are eligible for Title XX services based on individual income eligibility requirements and they still cannot obtain services.

Categorical programs offer the opportunity for federal design but still rely on state administrative structures for implementation. Thus, local advocacy is still needed if these programs are to be made available at locations and in a manner which permits migrants to utilize them. The sheer size of these programs and the obligations on the various levels of administration to consider the needs of the entire population make it difficult to tailor categorical programs to migrant needs.

Targeted programs, or direct federal intervention at the local level, are the most effective way to assure that a specific population obtains services; but targeted programs cannot be carried out on a large enough scale to meet the needs of all members of a population subgroup nationwide. Such federal programming requires careful administration at the local level to counteract resentment by those ineligible to participate over the apparent "special treatment" for the recipient group. Administration of a targeted program may appear to violate the local public social services agency's principle of equal treatment for all, refute its efficacy, or disrupt local coordination.

Thus, no single federal approach to service improvement can impact directly and comprehensively on the problem of under-served migrants nationwide. Where the equitable participation of migrants has been obtained, a substantial amount of advocacy for migrant programs already exists. Advocacy is usually found as an adjunct to a targeted, categorical program operated by a private, non-profit grantee, and serves to facilitate local program coordination. Although evidence indicates that the use of targeted programs should continue, eventually non-targeted programs may effectively meet the social services needs of migrant families.

User Perceptions: Do Child Welfare Services Help Migrants?

The survey of nearly 750 migrant families resulted in a considerable body of data that, while in need of cautious interpretation due to the methodological problems of sampling migrant farmworkers, shed a good deal of light on the findings obtained from other sources, by this project, and by the literature review (Porteous, S. M., Migrant Child Welfare). The family interviews are described, and results presented, in Part Three of this volume. Of further interest in this chapter are those findings concerning use of and attitudes toward social service programs.

The survey did not probe attitudes concerning use of specific agency services, but when asked about attitudes toward seeking help from various sources, almost one-half of the respondents indicated that they would seek help from a public social services agency. However, an equal number indicated negative reactions to using a welfare agency, while almost one-third of the families reported experiences during the previous year when the mother could not care adequately for the children in the household, social services agencies provided the necessary child care and chore services in less than six percent of the cases. Approximately one-half of the mothers, however, utilized agency resources for child care under normal conditions when they were working.

Thus, families queried did not as a rule turn to social services agencies to help with home management crises, although they often used agency resources for other kinds of assistance. Families were usually in their home base areas when situations arose in which the mother could not care for the children. This may be due simply to the length of time per year spent at home base. It seems more likely that such crises would develop in-stream, where dangers and drains on individual energy and resources are greater. It is these very demands, however, that can cause a mother to ignore personal conditions that at home base might lead her to seek assistance, due to the greater pressure on her in-stream to hold the family together and continue to contribute to family income.

In one out of ten cases in which the mother was incapacitated, no assistance was obtained to help with chores; in twice this number of cases, no one was available to care for the children. Generally, however, assistance was obtained, predominantly from the immediate or extended family. Respondents called on friends or neighbors for assistance very seldom but more frequently than they turned to agencies for help. None of the settled-out families utilized agency resources for child care or chore assistance when family services were needed. However, the sample of settled-outs was much smaller than the sample of current migrants.

Family planning information and assistance had been received in the previous year by almost one-half of the respondents. Of the other half, one-third indicated that they would like to receive it. The ages and number of children of those indicating desired services were not identified, although brief examination shows that many of those responding already had four or more children, or were over forty years of age, or both, so the actual unmet need may be less than indicated.

Migrant families were queried on major problems faced in child rearing in a migrant environment, and services that they felt were needed. Responses to questions concerning problems in raising children show the extreme situations of the migrant lifestyle and the extent to which child welfare cannot be separated from family welfare: over one-quarter cited problems that were not addressable by child welfare programs but did have an impact on children, such as the lack of food, money, and employment. Poor housing was the next most frequent problem, mentioned by one-fourth of the respondents as a major problem in-stream. Slightly fewer saw it as a major problem at home base, also. Child care needs were the next most frequent problem of the respondents, reported by greater numbers in-stream; and education, health, and recreation problems were also cited. Responses concerning new services desired correlated closely with problems cited.

Conclusion

The overall picture obtained through the family interview portion of the study vis-a-vis the migrant family and its relation to social services programs is that of a family continually in difficulty but self-sufficient and cohesive nevertheless. Agency interviews showed that little formal information on protective services utilization and other related child welfare services was available, but that there is a very low rate of uitlization of agency resources in times of family difficulty and a very high reliance on resources within the family unit. Beyond requests for temporary financial social services help, the migrant population does not often utilize social services. Cultural differences and personal reluctance by migrants to use these resources are also great; the programmatic and administrative barriers to their provision are substantial.

ADDENDUM TO

CHAPTER I: PUBLIC SOCIAL SERVICE AGENCIES

APPLICATION FOR ASSISTANCE
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
STATE OF WASHINGTON

STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES

APPLICATION FOR ASSISTANCE

INSTRUCTIONS: THE FOLLOWING IS A STATEMENT OF FACTS ABOUT YOUR SITUATION. PLEASE READ EACH QUESTION CAREFULLY AND ANSWER EACH ONE. THE INFORMATION YOU GIVE WILL BE USED TO DETERMINE YOUR ELIGIBILITY, THE AMOUNT OF ASSISTANCE AND NATURE OF SERVICES THAT YOU MAY RECEIVE. UPON COMPLETION OF THIS FORM, YOU WILL BE REQUIRED TO ATTEST TO THE FACTS SUBJECT TO PENALTIES AS PROVIDED IN RCW 74.08.055. PLEASE USE A BALL POINT PEN TO COMPLETE THIS FORM.

PLEASE PRINT YOUR FULL NAME AND ADDRESS BELOW **DATE AND SIGN LAST PAGE**

LAST NAME	FIRST NAME	MIDDLE NAME	OFFICE USE	BASIC NUMBER
MAILING ADDRESS	STREET ADDRESS (If Different)	APT. NO.		LOCAL OFFICE
CITY OR TOWN	ZIP CODE	TELEPHONE NOS WHERE YOU CAN BE REACHED 1. 2.		DATE OF REQUEST

I AM APPLYING FOR ASSISTANCE BECAUSE

I AM APPLYING FOR THE FOLLOWING PERSONS WHO ARE LIVING WITH ME. INCLUDE YOURSELF IF IN NEED OF ASSISTANCE. LAST NAME FIRST NAME MIDDLE NAME	BIRTH DATE Month	Day	Year	SEX	RELATIONSHIP TO ME	U.S. CITIZEN Yes/No	SCHOOL TAKE SCHOOL	SOC. SEC. NUMBER
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

NAME OF OTHER PERSONS LIVING WITH ME WHETHER RELATED OR NOT: LAST NAME FIRST NAME MIDDLE NAME	RELATIONSHIP TO ME	NOW RECEIVING WELFARE Yes	No	MONTHLY INCOME
1.				
2.				
3.				
4.				

I AM NOW: SINGLE ○ MARRIED ○ DIVORCED ○ WIDOWED ○ SEPARATED ○

IF SEPARATED, SHOW THE DATE THAT THE SEPARATION OCCURRED ....

I AM, OR A MEMBER OF MY HOUSEHOLD IS EXPECTING A BABY YES ○ NO ○

IF YES, EXPECTANT MOTHER'S NAME IS .... EXPECTED DATE OF BIRTH ....

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

APPLICATION FOR ASSISTANCE

[illegible]

IF YOU HAVE ANSWERED ALL QUESTIONS, TURN TO PAGE 2

REMOVE THIS SHEET AFTER COMPLETING PAGE 1 AND TURN IT IN WITH YOUR COMPLETED APPLICATION

p. 60 blank

READ CAREFULLY **READ CAREFULLY**

1. I AM NOW RECEIVING OR HAVE IN THE PAST RECEIVED FINANCIAL OR MEDICAL ASSISTANCE FROM A PUBLIC ASSISTANCE OFFICE OF THIS STATE (INCLUDING THIS OFFICE) OR SOME OTHER STATE. YES ○ NO ○

IF YES, WHICH OFFICE OR OTHER STATE? .... DATE LAST RECEIVED ....

WHAT WAS YOUR NAME AT THAT TIME? ....

2. I have, or a member of my household has received some type of income this month. YES ○ NO ○

IF YES, WHEN? .... WHAT AMOUNT? ....

SOURCE OF INCOME ....

3. I AM, OR A MEMBER OF MY HOUSEHOLD IS WORKING AT THIS TIME .... YES ○ NO ○

IF YES, COMPLETE BELOW

		NAME OF EMPLOYED PERSON		NAME OF EMPLOYED PERSON		NAME OF EMPLOYED PERSON	
a. EMPLOYER'S NAME							
b. EMPLOYER'S ADDRESS							
c. KIND OF WORK							
d. Total Number of Hours and Days Worked Per Month		TOTAL HRS	TOTAL DAYS	TOTAL HRS	TOTAL DAYS	TOTAL HRS.	TOTAL DAYS
e. How Often Are You Paid? (every day, week, month, etc.)		$		$		$	
f. Total Pay Per Pay Period (not take home pay)		$		$		$	
g. AMOUNT	1. Income Tax	$		$		$	
DEDUCTED	2. Social Security	$		$		$	
FOR	3. Union Dues	$		$		$	
(per pay period)	4. Other	$		$		$	
h. Total Take Home Pay (per pay period)		$		$		$	
DAILY	1. Bus Fare	$	PER DAY	$	PER DAY	$	PER DAY
i. TRANSP.	2. Number of Miles to and from Work		BOTH WAYS PER DAY		BOTH WAYS PER DAY		BOTH WAYS PER DAY
COST	3. Car Pool Cost	$	PER DAY	$	PER DAY	$	PER DAY

4. I HAVE, OR A MEMBER OF MY HOUSEHOLD HAS LOST A JOB OR QUIT WORKING WITHIN THE LAST SIXTY DAYS .... YES ○ NO ○

IF YES, COMPLETE BELOW

NAME .... HAS WITHIN THE LAST 60 DAYS: PLEASE CHECK (✓) EACH ITEM

	YES	NO
BEEN LAID OFF	○	○
GONE ON STRIKE	○	○
BEEN FIRED	○	○
QUIT WORK	○	○
REFUSED WORK	○	○
REFUSED A TRAINING ASSIGNMENT	○	○

COMPLETE FOR ANY "YES" ANSWER

a. WHEN .... b. WHY ....

....

....

c. AMOUNT OF PAY DUE $ ....

d. DATE EXPECTED TO RECEIVE PAY ....

IF YOU HAVE ANSWERED ALL QUESTIONS, TURN TO PAGE 3

p.62 illegible

5. I CONSIDER MYSELF ABLE TO WORK **AT THIS TIME** .... YES ○ NO ○
I CONSIDER MY WIFE OR HUSBAND ABLE TO WORK **AT THIS TIME** .... YES ○ NO ○
IF NO, EXPLAIN WHY FOR EACH ....
I last worked (date) .... My wife or husband last worked (date) ....

6. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME RECEIVE MONEY FROM THE FOLLOWING SOURCES. (Check each item "Yes or No")

SOURCE OF MONEY	YES (✓)	NO (✓)	APPLIED FOR (✓)	FOR WHOM	AMOUNT RECEIVED	CLAIM NO. (if any)	HOW OFTEN RECEIVED
a. Child Support Payments					$		
b. Social Security Benefits (1)					$		
c. Social Security Benefits (2)					$		
d. Railroad Retirement					$		
e. Supplemental Security Income (SSI)					$		
f. Veterans' Benefits					$		
g. Unemployment Compensation					$		
h. Military Allotment					$		
i. Indian Payments (Per Capita)					$		
j. Industrial Accident Payments (Labor & Industries)					$		
k. Payment from Boarders					$		
l. Money from Relatives					$		
m. Money from Rental Property					$		
n. Caring for Children					$		
o. Other Money or Benefits (not wages)					$		

7. I AM, OR A MEMBER OF MY HOUSEHOLD IS AN ENROLLED INDIAN .... YES ○ NO ○
IF YES, NAME OF TRIBE IS .... NAME OF MEMBER IS ....
DOES YOUR TRIBE HAVE BURIAL BENEFITS? .... ○ ○

8. I AM, OR A MEMBER OF MY FAMILY IS, OR WAS, A VETERAN OF THE ARMED SERVICES. YES ○ NO ○
IF YES, NAME OF VETERAN IS/OR WAS ....
V.A. CLAIM NO. IS .... SERVICE NO. IS ....
TIME IN SERVICE WAS FROM (date) .... TO (date) ....

9. I AM NOW MAKING CHILD SUPPORT PAYMENTS .... YES ○ NO ○
IF YES, TOTAL MONTHLY PAYMENTS ARE $ .... COURT ORDER NO. IS ....

DSHS [illegible]

READ CAREFULLY **READ CAREFULLY**

10. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME HAS SOME KIND(S) OF INSURANCE, (LIFE, BURIAL, ETC. DO NOT INCLUDE MEDICAL) .... YES ○ NO ○
IF YES, COMPLETE BELOW

KIND OF INSURANCE	NAME OF COMPANY	POLICY NO	FACE VALUE	DATE ISSUED	CASH VALUE	NAME OF INSURED	NAME & ADDRESS OF BENEFICIARY
a.							
b.							
c.							

11. I, MY WIFE OR HUSBAND, OR A DEPENDENT LIVING WITH ME, HAS SOME KINDS OF MEDICAL INSURANCE (INCLUDE VETERANS, MEDICAL COVERAGE THROUGH AUTO INSURANCE). IF YES, COMPLETE BELOW YES ○ NO ○

NAME OF INSURANCE CO. UNION OR OTHER	NAME OF PERSON COVERED	MONTHLY PAYMENT	DOES THIS PAY FOR						OTHER COVERAGE (OXYGEN, AMBULANCE ETC.)
			HOSPITAL		DOCTOR		DRUGS		
			YES	NO	YES	NO	YES	NO	
a.		$							
b.		$							
c.		$							

12. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR HAVE A SHARE IN ONE OR MORE OF THE FOLLOWING ITEMS. YES ○ NO ○
IF YES, COMPLETE BELOW

ITEM	AMOUNT OR VALUE	WHO IT BELONGS TO	WHERE IT IS LOCATED (Name of Bank If Applicable)
a. MONEY ON HAND	$		
b. Money Held for You by Others	$		
c. CHECKING ACCOUNT	$		
d. SAVINGS ACCOUNT	$		

13. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR HAVE A SHARE IN ONE OR MORE OF THE FOLLOWING ITEMS. STOCKS, BONDS, SALES CONTRACTS, RETIREMENT FUND, TRUST ACCOUNT. YES ○ NO ○ IF YES COMPLETE SUPPLEMENT

14. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR IS BUYING ONE OR MORE OF THE FOLLOWING VEHICLES. YES ○ NO ○
IF YES, COMPLETE BELOW

VEHICLE	MAKE AND YEAR	MODEL	APPROX VALUE	AMOUNT OWED
a. AUTOMOBILE			$	$
b. AUTOMOBILE - 2			$	$
c. TRUCK			$	$

15. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR IS BUYING ONE OR MORE OF THE FOLLOWING ITEMS: BOAT, SNOWMOBILE, CAMPER, TRAILER, MOTORCYCLE, OR SIMILAR ITEMS .... YES ○ NO ○ IF YES COMPLETE SUPPLEMENT

IF YOU HAVE ANSWERED ALL QUESTIONS TURN TO PAGE 5

[illegible]

16. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS O[illegible]UYING ONE OR MORE OF THE FOLLOWING ITEMS: LIVESTOCK, POULTRY, CROPS, TI[illegible]R, BUSINESS EQUIPMENT, MINING OPERATION, TOOLS, FARM MACHINERY, OR SIMILAR ITEMS ...... YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

17. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME HAS [illegible]ADED, OR GIVEN TO SOMEONE **PERSONAL PROPERTY** (Such as cars, cash inves[illegible]oney) WITHIN THE **LAST TWO YEARS** .... YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

18. I, OR A MEMBER OF MY HOUSEHOLD RECEIVES HOUSING FREE ON A REGULAR BASIS YES ○ NO ○

19. I RENT AND MY MONTHLY PAYMENT IS $ ....

I LIVE IN ONE OF THE FOLLOWING: (Please check which one).

○ BOARDING HOME ○ NURSING HOME ○ HOSPITAL ○ HOUSE ○ ROOM OR APARTMENT

I SHARE MY LIVING ARRANGEMENTS WITH ANOTHER PERSON(S) WHO IS RECEIVING AN ASSISTANCE GRANT YES ○ NO ○

I WE PAY SEPARATLEY FOR ONE OF THE FOLLOWING UTILITIES: ELECTRICITY, GAS HEAT, WATER YES ○ NO ○

20. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME **OWN** OR **AM BUYING** THE HOUSE IN WHICH I LIVE .... OWN ○ BUYING ○ (CHECK ONE) YES ○ NO ○

IF YES, COMPLETE BELOW

a. DESCRIPTION, INCLUDING NUMBER AND SIZE OF LOT(S) OR ACREAGE AND LEGAL DESCRIPTION.

b. MONTHLY PAYMENT $ .... c. BALANCE DUE $ ....

d. ARE YOUR YEARLY PROPERTY TAXES INCLUDED IN YOUR MONTHLY PAYMENTS? YES ○ NO ○

e. IF YOUR TAXES ARE NOT INCLUDED IN YOUR MONTHLY PAYMENTS, SHOW THE AMOUNT OF YEARLY TAXES SHOWN ON YOUR TAX STATEMENT. $ ....

f. ARE YOU PAYING FOR ANY ASSESSMENTS TO YOUR PROPERTY? (Such as for street improvements, sewer, sidewalk, irrigation, etc.) .... YES ○ NO ○

1. IF YES, WHAT TYPE OF ASSESSMENT(S) .... ANNUAL PAYMENT IS $ ....

21. I, **MY** WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME **OWNS** OR **IS BUYING** THE MOBILE HOME IN WHICH I LIVE .. OWN ○ BUYING ○ (CHECK ONE) YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

22. I, **MY** WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME **OWNS** OR **IS BUYING** SOME PROPERTY IN WHICH I AM **NOT** LIVING .... YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

23. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME **OWNS** OR **HAS** A SHARE IN SOME REAL PROPERTY **NOT ALREADY DESCRIBED** (Such as Life Estate or Indian Land) YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

24. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME HAS **SOLD, TRADED** OR GIVEN TO SOMEONE **REAL PROPERTY** (LAND OR BUILDINGS) WITHIN THE LAST TWO YEARS YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

[illegible]

READ CAREFULLY **READ CAREFULLY**

	YES	NO
25. I AM NOW MAKING "MEDICARE" MONTHLY PAYMENTS	○	○
MY WIFE IS NOW MAKING "MEDICARE" MONTHLY PAYMENTS	○	○
I HAVE, OR MY WIFE OR HUSBAND HAS APPLIED FOR "MEDICARE"	○	○

IF YES, NAME OF PERSON APPLIED .... DATE APPLIED .... CLAIM NO. ....

	YES	NO
26. I HAVE, OR A MEMBER OF MY HOUSEHOLD HAS A PREPAID FUNERAL PLAN (NOT LIFE INSURANCE) OR MONEY LEFT WITH OTHERS TO COVER FUNERAL EXPENSES	○	○

IF YES COMPLETE SUPPLEMEN

	YES	NO
27. I OR A MEMBER OF MY HOUSEHOLD OWNS OR IS BUYING A BURIAL PLOT OR PLOTS	○	○

IF YES COMPLETE SUPPLEMEN

	YES	NO
28. I WANT TO BUY FOOD STAMPS OR RECEIVE COMMODITIES	○	○
I WANT THE COST OF FOOD STAMPS DEDUCTED FROM ASSISTANCE PAYMENT OR I WANT FOOD STAMP PURCHASE CARDS ○ MONTHLY ○ SEMI-MONTHLY (check one)	○	○

	YES	NO
29. I HAVE BEEN LIVING IN WASHINGTON SINCE (Date)		
I INTEND TO KEEP MY RESIDENCE IN WASHINGTON	○	○

I declare under penalty of perjury that the information given by me in this declaration is true, correct and complete to the best of my knowledge and realize that willful falsification of this information by me may subject me to penalties as provided in Washington State Law, RCW 74.08.055.

I understand that I am required to report immediately to the local office any changes in my income, resources, or living arrangements.

I realize that my statements may be subject to complete verification by the Department of Social & Health Services. If I do not provide such verification, I hereby authorize the Department to contact other persons or agencies to obtain the necessary verification.

I understand that the information reported in this declaration will be used to determine my eligibility for public assistance and the amount of benefits I will receive.

BOTH HUSBAND AND WIFE MUST SIGN IF LIVING TOGETHER.

SIGNATURE OF APPLICANTS .... (Date)

.... (Date)

SIGNATURE OF PERSON HELPING APPLICANT(S) .... (Date)

IF APPLICANT SIGNS BY "X" ABOVE, HIS NAME SHOULD BE WRITTEN HERE BY A FRIEND OR RELATIVE .... (Date)

IF SIGNED BY "X" ABOVE, WITNESSES MUST SIGN HERE 1 .... (Date)

2 .... (Date)

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND SIGNED YOUR NAME

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

STATEMENT OF EMPLOYMENT AND HEALTH

Office Use Only	Case # __________ Worker __________

Please answer each question carefully. This information will be confidential and will be used in determining your eligibility for an appropriate public assistance program.

Print Your Name __________ (Last) (First) (Middle) Your birthdate __________

Your sex __________

Your Address __________

A. EDUCATION AND TRAINING

1. What was the highest grade you completed in school? __________

2. Have you ever received special training to learn how to do a job? Yes ____ No ____

If *YES* where was training? __________

What was the training? __________

When ? __________ How long ? __________

How long did you work as a result of the training ? __________

B WORK HISTORY

3. What do you consider your usual occupation? __________

4. What other kinds of jobs have you had ? __________

5. When did you work last ? __________ How long did you work? __________

What kind of work ? __________

6. How many jobs have you had in the last 10 years ? __________

7. What job have you worked the longest ? __________

When? __________

DSHS14-50(X)
REV. 3-75(2)

8. Have you ever *lost* or *left* a job because of your health? Yes ☐ No ☐

IF YES, what was the job? ____________________

When? ____________________

What was the health problem and how did it affect your work? ____________________

____

9. Have you ever been *turned down* for a job because of your health? Yes ☐ No ☐

What was the job? ____________________

When? ____________________

What was the health problem? ____________________

10. Do you have any health problem which prevents you from working now? Yes ☐ No ☐

IF YES, what is the health problem and how does it prevent you from working? ____________________

____

11. are there any other reasons you feel you cannot work now? Yes ☐ No ☐

IF YES, please explain ____________________

____

____

12. Do you keep house for anyone other than yourself? Yes ☐ No ☐

IF NO, do not answer the next questions — Go to Section C.

IF YES, do you need help with:

	Yes	No		Yes	No
Shopping for food and supplies			Washing and ironing		
Preparing meals			Scrubbing floors		
Washing dishes			Washing windows		
Cleaning house			Moving furniture		
Making beds			Child care		

C HEALTH AND MEDICAL INFORMATION

---

13. What health problems do you have at this time? ____________________

____

____

14. Are you under care of a doctor or clinic now? Yes ☐ No ☐

IF YES,

Doctor's or clinic's name and address ______________________________

____

What kind of problem? ______________________________

____

What does he tell you to do or not to do about your health? ______________________________

____

How long have you had this problem? ______________________________

IF NO,

When was the last time you were seen by a doctor or clinic? ______________________________

Doctor or clinic's name and address ______________________________

____

15. Do you take medicine that is prescribed by a doctor? Yes ☐ No ☐

IF YES, for what condition(s) ______________________________

____

____

D. BENEFITS

16. Have you applied or are you receiving disability benefits from:

	Yes	No
Social Security Administration	☐	☐
Veteran's Administration	☐	☐
State Department of Labor and Industries	☐	☐

I declare under penalties of perjury that the information given by me on this Statement of Employment and Health is true, correct and complete to the best of my knowledge.

I realize that my statements may be subject to complete verification by the Department of Social and Health Services.

SIGNATURE OF APPLICANT ______________________________ DATE ______________

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MEDICAL SUPPLEMENT

This form is for additional information about your particular situation. Please answer each question carefully. The information will be used in determining your eligibility.

NAME ______________________________

Office Use Only
Basic No.

1. I, my wife or husband, or a dependent living with me, am in need of medical care. Yes ○ No ○
If yes, complete below:

NAMES OF PERSONS IN NEED	MEDICAL PROBLEM
a.	
b.	
c.	
d.	

2. I, my wife or husband, or a dependent living with me, am NOW under a doctor's care. Yes ○ No ○
If yes, complete below:

NAMES OF PERSONS UNDER CARE	DOCTORS' NAME	DATE LAST SEEN
a.		
b.		
c.		
d.		

3. I, my wife or husband, or a dependent living with me, am NOW taking medicine that is regularly prescribed by my doctor. Yes ○ No ○
If yes, complete below:

NAMES OF PERSONS TAKING MEDICINE	PROBLEM MEDICINE IS FOR
a.	
b.	
c.	
d.	

4. I NOW owe for or am paying on the following services received in the LAST three (3) months: Yes ○ No ○

If yes, check appropriate boxes: ☐ Hospital, ☐ Medical, ☐ Other Health Care.

If yes, I owe $__________ and/or am paying $__________ per month.

After you have answered all questions - complete back of form if appropriate.

5. I am NOW paying on a bill, contract, or loan for home repairs. Yes ○ No ○

If yes, I pay $__________ per month and I still owe $__________.

6. During each of the LAST six (6) months, I have earned, after mandatory deductions:

1. Month __________ Amount $__________ 4. Month __________ Amount $__________

2. Month __________ Amount $__________ 5. Month __________ Amount $__________

3. Month __________ Amount $__________ 6. Month __________ Amount $__________

7. During each of the NEXT six (6) months, I expect to earn, after mandatory deductions:

1. Month __________ Amount $__________ 4. Month __________ Amount $__________

2. Month __________ Amount $__________ 5. Month __________ Amount $__________

3. Month __________ Amount $__________ 6. Month __________ Amount $__________

I declare under penalties of perjury that the information given by me on this form is true, correct and complete to the best of my knowledge.

I realize that my statements may be subject to complete verification by the Department of Social and Health Services.

Signature of Applicant(s) ______________________________ Date __________

______________________________ Date __________

DEPARTMENT OF
SOCIAL AND HEALTH SERVICES

EMPLOYMENT SUPPLEMENT

IMPORTANT: Please answer each question carefully. The information on this form will be used to determine whether or not you are eligible for financial assistance. If any part is unclear to you, be sure to ask about it. Fill out both sides.

Name ______________________________

Office Use Only
Basic No.

1. The following is a record of my employment during the periods of time shown below. I earned $50 or more during each of the time periods checked.

TIME PERIOD	EARNED $50 OR MORE? (Check if "yes")	NAME and ADDRESS of EMPLOYER
This Calendar Year: (19) Oct. through Dec.		
July through Sept.		
April through June		
Jan. through March		
Last Calendar year: (19) Oct. through Dec.		
July through Sept.		
April through June		
Jan. through March		
Two years ago: (19) Oct. through Dec.		
July through Sept.		
April through June		
Jan. through March		
Three years ago: (19) Oct. through Dec.		
July through Sept.		
April through June		
Jan. through March		
Four years ago: (19) Oct. through Dec.		
July through Sept.		
April through June		
Jan. through March		

(OVER)

DSHS 14-07(X) Rev. 12/74

2. Enter the number of hours worked this month and in the preceeding three (3) months.

______________________ ________ (Current Month)
Month Year Hours

______________________ ________
Month Year Hours

______________________ ________
Month Year Hours

______________________ ________
Month Year Hours

3. I last registered for work at Washington State Employment Service on ______________.

4. Check one of the following statements:

☐ I am receiving unemployment compensation.

☐ I applied for unemployment compensation on (Date) ______________.

☐ I applied for unemployment compensation on (Date) ______________ but received notice that I am not eligible.

☐ I have not applied for unemployment compensation.

5. I have received unemployment compensation within the last year. Yes ☐ No ☐

I declare under penalties of perjury that the information given by me on this form is true, correct and complete to the best of my knowledge and realize that willful falsification of this information by me may subject me to penalties as provided in RCW 74.08.055.

I realize that my statements may be subject to complete verification by the Department of Social and Health Services.

Signature of Applicant(s) ______________________ Date ______________

______________________ Date ______________

(Be sure you have filled out both sides of this form)

STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES

FOOD STAMP SUPPLEMENT

1. INCOME. List all earned income received by each person in the economic unit; plus all student loans, grants, scholarships, VA benefits, SS, SSI, PA, retirement benefits, support/alimony payments received. Have documents to verify.)

Name of Person Receiving Income	Source of Income (Name & Address of Employer)	Pay Period (frequency)	Gross Pay Each Period	MANDATORY DEDUCTIONS			
				Income Tax	FICA	Other Item	Other Amount
			$	$	$		$

2. Have all persons in the household between the ages of 18 and 65, able to accept work but employed less than 30 hours per week, completed a Work Registration form (FNS-284)? ☐ Yes ☐ No

List the names of persons not registered and explain why.

3. (a) Have you ever applied for and/or purchased food stamps before? ☐ Yes ☐ No

(b) If yes, when .... where ....
Date

4. Do you have cooking facilties? ☐ Yes ☐ No

5. If you are renting your house or apartment do you pay separately for any utility? (heat, cooking fuel, electricity, telephone, water or sewage) ☐ Yes ☐ No

6. (a) Do you or a member of your household pay school tuition or mandatory fees for education? ☐ Yes ☐ No

If yes,

(b) When are they paid? ....

(c) To whom ....
name of school

(d) Student's name ....

(e) What is the average monthly amount? ....

(f) How long will this continue? ....

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7. (a) Do you or a member of your household pay more than $10 per month for medical expenses? ☐ Yes ☐ No

If yes,

(b) Amount paid per month

(c) For what

(d) How long do you expect to pay this amount?

8. (a) Are you or a member of your household making a monthly payment for a personal disaster? (funeral, fire, flood, theft, vandalism) ☐ Yes ☐ No

If yes,

(b) For what

(c) In what amount

(d) How long do you expect this to continue?

9. Does any household member pay court ordered support/alimony?

If, yes,

Amount paid $ Frequency

To whom paid?

How long do you expect to pay this amount?

10. Do you pay guide dog expenses? ☐ Yes ☐ No
If yes, how much each month $

11. Do you want the amount you pay for food stamps deducted from your public assistance warrant and the food stamps mailed directly to your address? ☐ Yes ☐ No

12. Does anyone in the household plan to purchase home delivered meals? ☐ Yes ☐ No
If yes, list their names and indicate whether any are housebound, feeble or disabled.

Name

Name

13. (a) Do you want to authorize someone else to purchase your food stamps? ☐ Yes ☐ No

(b) If yes, give that person's name and address below.

Name Address

I declare under penalties of perjury that the information given by me in this application form is true, correct, and complete to the best of my knowledge and realize that willful falsification of this information by me may subject me to penalties as provided in RCW 77.08.055.

I understand that it is my duty to report immediately to the local office any changes in my income, resources, or living arrangements.

I realize that my statements may be subject to complete verification by the Department of Social and Health Services.

I understand my rights to a Fair Hearing.

Signature of Applicants Date

Date

Both husband and wife must sign if living together.

Standards for partcipation in the Food Stamp program are the same for everyone without regard to race, color, religious creed, national origin, or political beliefs.

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- NOTICE TO APPLICANTS -

Your application is subject to complete verification of all items that directly relate to your eligibility for Public Assistance. Please have the requested information available.

Your application cannot be processed until all items are verified. Any item you answered "Yes" or completed must be supported with the appropriate documents.

Please see the following list for items that are subject to verification and what may be used for verification.

Items to be Verified	Examples of Acceptable Verification
( ) Personal identification - age	Driver's license, birth certificates, school records, baptismal records, draft cards, military records.
( ) Relationships - marital status	Birth certificates, marriage certificate, divorce and/or separation document, death certificate.
( ) Pregnancy	Doctor's statement showing expected delivery date.
( ) Child support-paid or received	Court order, cancelled checks, money orders.
( ) Social Security, Retirement or Disability	Award notice, actual check " " " "
( ) Railroad Retirement	" " " "
( ) Veterans Benefits	Award notice, actual check. VA Hospital or medical identification card.
( ) Labor & Industries (L&I)	Award letter, actual check, claim number.
( ) Unemployment Compensation	Award notice, actual check, U.C. booklet
( ) Indian Benefits	Award notice, tribal registration
( ) Military Allotment	Award notice, actual check.
( ) Wages, earned income (working)	Check stubs, verification of wages from employer.
( ) Insurance: Medical, Life, Burial	Policy, company name, face value, etc.
( ) Bank Account: checking, savings	Savings book, bank statements
( ) Stocks, Bonds, Contracts, Savings Certificates, Trust Fund	Actual bonds, contracts, etc.
( ) VEHICLES - Cards, Trucks, Motorbikes, Boats, Trailers, Snowmobiles	Titles, registration slips, payment book

(OVER)

NOTICE TO APPLICANTS - (2)

Items to be Verified	Examples of Acceptable Verification
( ) Social Security and/or Medicare Claim Number Veteran's Number	Social Security Card and Medicare Card Discharge papers.
( ) Real property (land and house) Must include legal description. Separate lots.	Tax statements, irrigation assessments, sales-purchase contract, mortgage papers, payment records, deeds, titles.
( ) Rented property	Rent receipts complete with landlord's name, address and telephone number; lease agreement, utility statements.

C YF10 (6-74)

FOR OFFICE USE ONLY

Discussed with Client

	Yes	No
Right to Fair Hearing	____	____
Civil Rights	____	____
Confidentiality	____	____
Changes in Circumstances to be rep't in writing	____	____
Penalties of Perjury	____	____
Food Stamp Program	____	____
Medi. Program	____	____
Social Services	____	____

The above rights and responsibilities have been explained and the applicant(s) stated they understood

______________________ Date

______________________ Financial Service Technician

CHAPTER II

CHILD CARE

Adequate child care is a pressing need of the migrant family. When migrants travel with their families, it is essential that most adult members work to provide the family with necessities. Parents usually do not have the option of staying home to care for the children. The income earned by older children is often needed, too, so in many cases no one can be spared to care for young children. When day care programs are unavailable or inaccessible, children accompany their parents to the fields. Under the best of circumstances, when the weather is good, infants and children are inevitably exposed to plant pesticides, are left to crawl or play in the dirt, and are deprived of attention, supervision, and care.

Migrant parents whose children are not in day care programs are dissatisfied with the present makeshift arrangements. When they were interviewed and asked to state the main problems while in-stream, they ranked the need for child care second only to housing as the most critical problem. At home base, day care was not identified as a critical problem, but several factors may account for that fact. There may be a somewhat greater availability of child care facilities, fewer mothers who work while they are in home base, and more relatives who can provide child care. When asked specifically about the need for child care, in all geographic areas more than half of the migrant parent respondents indicated they needed child care for those children not already in day care facilities.

Day care centers which provide quality care, suitable hours, and supplemental services, including transportation for children, can relieve parents of the psychological as well as the physical burden of caring for their children while they work. Most day care providers furnish a comprehensive range of services to the children which spares parents the time and effort of soliciting needed services from different provider agencies. Such services typically include medical examinations, immunizations and health treatment, and free, nutritious meals. Many centers also offer educational programs, taking into account the children's special needs and cultural and language backgrounds. Such programs are an added benefit and can influence the child's future to a considerable degree. Although programs with an educational component furnish an optimal setting for child development, basic care programs which would simply protect and encourage children's physical and emotional growth are preferable to days spent in the fields. However, even this minimal type of program is not yet universally available to the children of migrant families.

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Funding Sources

The money for provision of day care to migrant children comes from five major sources. The Title I Migrant Education program is by far the largest provider of day care. Migrant Head Start, Title XX of the Social Security Act, state allocations, and the Comprehensive Education and Training Act (CETA) are also responsible for providing day care to migrant children nationwide. While it is impossible to determine exact numbers of children served, the numbers obtained for Migrant Head Start, CETA, and state programs appear to be reasonably accurate. The number actually served by Title XX money is difficult to estimate since only one state level Title XX agency kept separate records identifying services to migrant children. The only figures obtained for numbers of children served by Title XX programs were those provided by local day care centers. Since the centers surveyed were generally located in only the target county of each state, the numbers furnished cannot be considered comprehensive. Title I Migrant Education figures may be accepted as accurate, however, the number of preschool children served was not known by the New Jersey state office although local education agencies reported providing preschool care.

Title I Migrant Education Preschool

The data collected indicate that the Title I Migrant Education program provides preschool care to more migrant children than any other funding source. According to available figures, Title I Migrant serves 17,063 preschool-aged children in the 12 states sampled. The greatest numbers of children served are in the states of Florida, Michigan, and Texas. Although the actual number of children served is greater in these home base states than elsewhere due to the larger migrant populations, Title I Migrant is also the major preschool care provider in North Carolina and Maryland. In Iowa, Colorado, and New Jersey, Title I Migrant Education does not aid in providing preschool care or does only to an insignificant degree.

Title I Migrant operates and administers preschool care as an independent provider in seven of the twelve states studied. Through federal funds applied for and distributed by state education agencies, care is provided for younger siblings of school-aged children by the local agencies at their own discretion. Administration of the preschool program is handled by the established structure of the Title I Migrant school-age program. Generally the preschool programs are housed in the same school facilities which are used for the school-age program, thus simplifying transportation and administration. Planning for staffing and programs can be handled by school administrators in advance of program openings in the spring. Supplies and equipment can be stored in the schools during the winter months when they are not needed.

Notwithstanding the apparent simplicity of Title I Migrant operation of preschool programs, there are many difficulties to be faced each year. Funding is the most critical problem. While funding provided for Title I Migrant school-age programs appears to be adequate, there is no separate funding base for preschool programs. According to Title I

Migrant Education regulations, preschool-age siblings may be served only when service provision for them does not detract from the program for school-age children. Since the cost per child for preschool programs far exceeds that for school programs, plans must be made carefully to ensure the maximum use of every dollar. Licensing requirements for preschool programs include specifications on such items as staffing ratios, furniture size, cots, and fire regulations. Preschool programs must also bear the expense of transportation of the children. Licensing requirements and transportation costs have prompted some state Title I Migrant directors to wonder how long they can continue to provide preschool care without additional funding for such programs.

Migrant Head Start

Migrant Head Start preschool programs represent the second largest child care provider and serve approximately 6,000 migrant children. Seven of the twelve states sampled offer preschool funded by Migrant Head Start. In most of these seven states, Migrant Head Start preschool programs are operated by either the East Coast Migrant Project, which serves nine eastern stream states, or the Texas Migrant Council project, which serves ten states. A few states, such as Colorado, have separate grants.

Migrant Head Start grantees apply directly to the Indian and Migrant Programs Division (IMPD) of the Office of Child Development at the federal level. Grantees are then responsible directly to IMPD.

Migrant Head Start is the only migrant preschool funding source that specifies the nature of the program in the grant. Two categories of programs, local and national, are funded by Migrant Head Start. All of these programs use the Head Start curriculum, but they differ in other aspects. Some of the local programs are Head Start programs which accept migrant children, but do not extend special services to the relatively few migrant children served. Other local programs respond to the specific needs of migrants through the provision of three special features: extended hours of operation; bilingual/bicultural staff, where appropriate; and inclusion of infants in the program.

The national programs are organized according to either the Prime Grantee model or the Network model. Both models are tailored to meet the needs of migrant families. The Prime Grantee model funds programs in regions that have field work periods of four or five months. In this way, families remaining for the entire work season have access to a full service program, and the children benefit from the educational continuity provided by the lengthened program. The major problem encountered in the operation of the Prime Grantee model is the recruitment of qualified personnel. The operation time of the program usually overlaps with the regular school year, and many teachers can accept only summer or full-time contracts.

The Network model programs follow migrant streams during work season and provide child care where large concentrations of migrants are found.

Staff can be regrouped as needed at the various centers to accommodate changes in the target population.

The federal ceiling on all Head Start funds is fixed yearly by Congress, and the amount allocated to Migrant Head Start is an administrative decision. Thus, the provision of Migrant Head Start is limited, and reaches relatively few children nationally.

Title XX Day Care

According to available figures, Title XX funds provide child care to the third largest group of migrant children. While information indicates that 3,417 children are served through Title XX, the actual number may differ greatly due to the unavailability of data. Nevertheless, some general statements can be made concerning Title XX as a funding source. In most states, Title XX money is administered by the state departments of social services through their local offices. Federal money is matched by a 25% state share. In some states, however, the counties must contribute part of the state share and county approval of the state services program is necessary.

In other words, the Title XX funding structure makes the provision or nonprovision of programs a local option. As a result, services may be fragmented across counties and the eligibility requirements and availability of services may differ within states. Colorado and North Carolina are examples of states where counties exercise their local options. The target county in North Carolina used the local option to reduce the number and amount of services offered, to the detriment of the poor. On the other hand, decisions in the target county in Colorado made fewer people eligible for day care on the basis of income, but permitted the provisions of day care to two-parent families.

While some counties may choose not to provide certain services, others which decide to make services available may find insufficient funds with which to carry out their programs. Eight of the twelve states sampled were operating at their ceiling for Title XX. That is, the states had appropriated sufficient matching funds to enable them to receive the maximum federal share available to them in fiscal year 1975. Therefore, if additional money is needed for a specific target population, such as day care for migrant children, state personnel often reported that money would then have to be shifted from other programs, forcing a reduction of services in those areas. One alternative to a reduction in one service area in favor of another area is state support of services in excess of the matching funds required by Title XX. For example, California and New York appropriate additional funds for the support of special social service programs. In many states, however, popular interest in social service programs is too weak to convince the state legislatures to appropriate the necessary additional funding. Rallying support for specific funding for services to migrant children is even more problematic.

State Allocations

Individual states constitute the fourth largest provider of migrant child care in terms of numbers of children served. In New York and California, a portion of the state budget is set aside for migrant child care. Some 2,150 migrant children received day care funded by state allocations. New York state provides day care for an estimated 1,500 children through its Department of Agriculture and Markets. In California, state money, if used separately, would provide child care for about 650 children. In practice, these funds are coordinated in the California Office of Education with part of the state share of Title XX money plus funds from Title I Migrant Education.

There are advantages and disadvantages to state-funded day care programs. State funding offers the possibility of consolidating administration of all migrant day care services within the state. On the other hand, if a state has constructed a centralized program using multiple funding sources, it may be dependent upon renewed funding from each source yearly for continuance of the whole package. In the state of New York, migrant day care is possible only through the coordination of various funds, and the discontinuance of any single source will jeopardize the entire state-operated program. While ceilings on available state funds are flexible, and may be adjusted yearly to meet the need for migrant child care, it is difficult to obtain increases, and strong lobbying may be necessary just to maintain present funding levels.

CETA Day Care

The Comprehensive Employment and Training Act (CETA) is the only other provider of funds for migrant day care, with the exception of a few scattered local groups such as church-affiliated sponsors. In the 12 states surveyed, CETA money reportedly provided for an estimated 1,225 children. This total excludes those served in New York and Washington states, where the number served by CETA funds could not be separated from the total number served by day care programs and CETA is only one source of funds. In only one state does CETA funding appear to have major impact on the child care needs. In Colorado, 1,000 children are served with CETA money. This is more than 80% of the total number served with CETA funds in the sample, and two-thirds of the number of children served within Colorado. Of the remaining states, nine use some CETA funds, but generally the proportion of day care needs met by CETA money in each state is quite small.

The provision of day care is intended by CETA to be a supportive service for its manpower training program for adult migrants. However, CETA funding for day care is a component of the adult program. Thus, day care may be provided for children of migrants enrolled in the CETA program. In any case, CETA is neither designed nor intended to be a major provider of day care to migrant children. The money is often insufficient for the operation of day care centers, and in such cases, children are provided slots in existing centers. Additionally, grantees are not evaluated for the provision of a child care component. The only incentive for the provision of child care is that it facilitates the recruitment and participation of adults in the program. Without additional funds or a revision of CETA regulations which broaden the scope of services to emphasize child care provision, CETA funds will not make a significant contribution to meeting the needs for migrant child care.

Program Implementation

Most of the providers of day care for migrant children are cognizant of the needs of the children and parents, and, in most cases, programs are adapted to meet those needs. Programs funded by Migrant Head Start and Title I Migrant Education are at an advantage because they are provided with established curriculum guidelines. In the case of Migrant Head Start, materials to aid in program development are also provided. Other providers create their own programs based on their perceptions of the needs of the specific families they serve. Often training and technical assistance are provided by the state departments of social services or a related agency, such as the California Office of Child Development.

Shared aspects of most migrant child care programs include a carefully designed curriculum which considers all aspects of children's growth and development; nutrition programs; health screening, diagnosis and treatment; parent involvement; hours compatible with parents' working hours; transportation; and, often, outreach to families and referrals to social service provider agencies. Although each of these services is generally stated to be a component of migrant child care programs, parents cannot rely on finding great apparent similarity between programs. If children are enrolled in different centers during the year, as is often the case, then the services, the atmosphere, and type of attention they receive will also differ from center to center. Child care programs differ widely in their implementation of the various components. There are excellent programs with enthusiastic staff, obvious personal caring for the children, a suitable curriculum, and high parent involvement. At the opposite extreme, there are programs that appear to be custodial in nature, exhibit a low level of staff involvement with the children, and lack educational materials.

Several factors appear to contribute directly to the success or failure of child care centers: the commitment and competence of the staff, the appropriateness of the program for meeting migrant families' needs, and community responsiveness and support. These factors rarely develop spontaneously or maintain themselves in an isolated setting. The development of these critical factors can be encouraged and sustained by administrative and programmatic support and adequate funding.

Administrative Support

Administrative support is necessary if day care sponsors are to venture beyond the initial planning stages. Such support may include helping to locate facilities that meet day care licensing guidelines, interpreting the various regulations, facilitating funding and payment procedures, and providing coordination.

One of the most common problems encountered by day care providers is that of locating facilities which can be licensed. In many areas, it is difficult, if not impossible, to locate facilities that can be licensed by the states. Often the most sound facilities are those of the public schools which are willing to house a day care program. Even these, however, do not usually meet the standards of the Federal Interagency Day Care Requirements (FIDCR). None of the states studied provide temporary licensing with standards adjusted to meet the needs of seasonal programs. In California and New York, however, the necessity of compliance with the FIDCR is circumvented by using that portion of Title XX money which is contributed by the state for day care. Thus, the facilities are exempt from the regulations linked to the use of federal money. The majority of seasonal programs in California are housed in migrant camps in facilities which cannot easily be brought up to the licensing standards of FIDCR. In many of the other states, the licensing of seasonal day care facilities never takes place during the period of operation, probably due to the necessary time lag between application and inspection for licensing. It is possible that, in some cases, there is a form of benign neglect in which migrant centers are not processed for licensing simply because so many could not meet even the state guidelines. There would be little day care available for migrant children if licensing requirements were enforced.

Difficulties in funding and payment processes were often cited by day care providers. Varying administrative arrangements seemed to ease or complicate these procedures. In some states, such as Colorado, California, and New York, a state agency or organization secures funding for migrant child care from several sources and then coordinates those funds for maximum program effectiveness. In states which do not have a centralized administration to coordinate all migrant child care programs, a state-level coordinator may be provided by any funding source to coordinate the migrant child care programs it sponsors. For example, all the Title I Migrant preschool programs in a state are coordinated by the state Title I Migrant director. Day care directors at the local level depend on state program sponsors for all administrative assistance, which includes funding and payment procedures. If administrative procedures are not clearly delineated, local programs cannot continue to function.

State-level coordination between day care sponsors can also effect local day care staff indirectly. Frequently, local day care projects may have little or no contact with other projects in the same area. For example, in one area of Michigan there are four day care providers serving children of Berrien County. They are Title I Migrant Education; United

Migrants for Opportunity, Inc., a farmworker organization; a local church group; and a university. Two of these providers work in adjoining counties. Some of their programs may receive administrative assistance from their respective funding agencies but they do not have the opportunity to benefit from shared experiences.

In addition to helping locate facilities which can be licensed, providing technical assistance in funding, and maximizing coordination among providers, administrative support personnel could facilitate reimbursement procedures and reduce the great burden of paperwork necessary for enrollment and record keeping for children. Directors of centers using Title XX funds consistently reported spending an excessive amount of time filling out the necessary forms. In some states, as many as six forms must be completed for each child enrolled in day care. Since day care services in most states are provided by different agencies or organizations, and are not under a centralized administration, each day care may have its own forms in order to comply with its funding requirements. Thus, both parents and day care personnel are subjected to lengthy and repeated admissions procedures as families move during the season.

Some day care center directors discussed the absence of clear established procedures for resolving routine administrative matters with Title XX funded agencies. All such administrative matters were handled by the state level of the social service agency. Although the local level social services agency was generally more accessible, the local staff must refer procedural or reimbursement problems to the state.

Centers funded by Title I Migrant have access to the established administrative structure of Title I Migrant programs, which have demonstrated previous experience in migrant children's programs. The efficiency with which preschool administrative matters are handled thus depends to a large extent on the effectiveness of the state Title I Migrant project.

Providers using CETA, Head Start, or state funds rely on their respective sponsoring agencies for administrative assistance as needed. Generally, it was felt that the administrative burden was lessened for those day care providers who were not dependent upon Title XX, with the possible exception of a few cases where adequate administrative support was supplied by the Title XX sponsoring agency.

Programmatic Support

A factor of critical importance in the quality of care provided to children is that of programmatic support. This area encompasses both staff development and resource development. Although resource development could possibly be considered a part of staff development, resource development for migrant child care centers is discussed below and in broader terms to include aspects not generally thought of as critical to the successful operation of day care centers.

Staff Development - There is a broad consensus among migrant day care providers and sponsors that staff development is an important factor in the success of child care programs. Nearly all of the programs studied include some form of staff development. In some states, such as Washington, Colorado, New York, and California, a link has been established between some migrant child care programs and local colleges or universities to train participating child care staff. These programs generally make it possible for the staff members to earn either a Child Development Associate degree or its equivalent. Programs in other states provide staff with in-service training in specific topics, such as child development and cultural awareness. In a few cases, staff development appears to focus primarily on administration, such as enrollment forms and record-keeping. Many staff members and sponsors alike complained that start-up time was inadequate to prepare the facility, to obtain educational materials and necessary supplies, to organize the centers, and to hire staff and train them before the arrival of the children.

The frequency as well as the quality of staff development varies also, often depending on whether the program is seasonal or year-round. Staff in some of the seasonal centers receive no training. Staff in some year-round programs, such as in Florida, receive in-service training several times throughout the year. Insufficient program funding was the major explanation for the lack of essential organizational and training time prior to the opening of seasonal centers. In many cases, training was deferred indefinitely. The staff suffers from the administrative strains and lack of training prior to the reopening of seasonal centers. The lack of investment in staff is reflected in the quality of programs available to the children.

Many centers do not have access to agency personnel with expertise in child development and familiarity with the diverse cultural backgrounds represented in their enrollment. Departments of social services, farmworker organizations, and other agencies often have personnel designated to provide training and technical assistance to child care centers. Due to the short duration of many summer programs, however, such resources do not reach local child care centers as often as needed. This type of technical assistance is essential to provide the staff with new curriculum ideas, discuss application of child development theories, and enable the staff to deal effectively and caringly with individual children.

Staff Morale - Staff morale is a vital, but easily overlooked, factor in the operation of migrant child care centers. Staff morale has an indirect but nonetheless strong influence on the children, as it reveals itself through all staff interaction with the children. This is particularly true with seasonal centers because the time is so short between the preparation and the dismantling of programs, and priority in staff development may be focused on content areas, which are seen to have a direct effect on children. As a result, necessary staff support functions, which promote morale, may be omitted from programs.

While the nature of migrant day care operations makes it difficult to provide the support necessary for achieving a high level of staff morale, the need for such support is heightened by the demands of caring for migrant children. The care of young children in a group setting is an arduous task, even under the most supportive circumstances. In seasonal centers, the relationship between teachers and children may be brief, and the satisfaction derived from ongoing relationships may be denied them. In addition, there are various aspects of the lifestyle of migrant children which require increased patience and understanding from day care staff. Migrant children are mobile, and may arrive at a particular center, just one more stop-over during the summer, tired from being awakened early, or hungry after a long bus ride, or just simply "out-of-sorts" from continuously adapting to different environments and new people. Consequently, working with migrant children on a daily basis requires a great deal of flexibility in responding to the children. Teachers at migrant day care centers thus need genuine appreciation, such as support from staff directors, sponsors, and resource personnel for their continued work, and reassurance that their efforts are meaningfully contributing to the lives of the children.

Much of the necessary staff support can be incorporated into regular in-service meetings. Additional sessions in which the staff members learn how to deal constructively with their own interpersonal relationships could be beneficial to the overall program. Children can profit both from the more relaxed atmosphere and from observing cooperation and consideration between adults.

An additional factor which aids in raising staff morale and promotes staff development is the granting of academic credit for in-service training or education. Some programs are beginning to make study for a Child Development Associate degree an integral part of migrant day care operations. Although these programs tax the child care staff, they also help to improve the quality of child care and present new goals for staff members who might otherwise lack purposefulness once they have mastered basic child-care skills.

The method and means of providing staff development and support will best be determined by migrant child care sponsors and providers through a continuing informal assessment of need. It is clear that such support is critical to fostering increased competence and a heightened sense of purpose among child care staff. Staff development and support will produce immediate benefits in improved child care and long-term results in greater staff commitment.

Development of Community Resources - The development of community resources can yield valuable support to migrant day care programs. These resources may take several forms: materials, expertise, volunteer personnel, increased opportunities for children's activities, and greater community appreciation of the migrant child care center. Any of these types of contributions would ease the burden of the child care staff and promote a sense of cooperation between the community and the center.

Staff members at many migrant child care centers reported feeling isolated and often discriminated against by members of their local communities. In some states, family day care mothers refused to care for children of migrants. Directors of migrant day care centers will, of necessity, have an influence on the community. Through their administrative functions, they can affect community attitudes. For example, in the course of coordinating their programs with service agencies and organizations, day care center directors could educate those groups to the role and needs of migrants. Hopefully, this approach to the community will be shared by the local farmworker organization, and the impact of such an effort would be reinforced and broadened.

Often, the tasks of maintaining the day care programs prevent the staff from investing the necessary time in the community. If community resources are to be developed, the assistance of staff development persons from sponsoring agencies will be required. If center directors are helped to manage tasks as efficiently as is consistent with optimal child care, then some time may be available for community outreach activities. Through staff development, directors may also learn methods for initiating community contact and for integrating discussions of cooperative efforts into routine administrative contact with local agencies and organizations. As personal relationships are developed with community services providers, the benefits may eventually extend to adult migrants as well, with increased acceptance of migrants' contribution to the areas where they live and work.

Conclusion

The major problem in meeting the great demand for migrant child care is that of securing enough money to support current programs and expand services. Only one federal funding source, Migrant Head Start, includes day care for migrant children as a priority. It is impossible for the relatively small amount of Migrant Head Start money to have a major impact on the day care needs nationwide. States do have the option of establishing and apportioning state money specifically for migrant day care. The states of California and New York have demonstrated a serious commitment to migrant child care by funding the programs directly. In other states, most of the programs are totally dependent upon their ability to acquire funds from several possible sources. The state legislatures control Title XX money, which must serve diverse constituencies. CETA is a possible funding source, but has only limited application. Although Title I Migrant Education is providing child care for more than half of the migrant children served, it does not have a clear directive to provide the care.

Thus, maintenance of programs at the present service level is not assured. Although some states approach the goal of providing child care to all migrant families that need it during at least part of the year, there is no national goal to ensure that migrant children receive the basic care which is essential to their well-being.

It is possible to meet the goal of providing day care to migrant children through present federal programs. The federal government could appropriate additional funds through one or both of the two programs best suited to provide migrant child care, Migrant Head Start or Title I Migrant Education. At present, Migrant Head Start is the only federal program that provides child care designed especially to meet the needs of migrant children. Title I Migrant Education legislation would require a provision for using the number of preschoolers it serves as a funding base, as is now done with school-aged children. Such an arrangement would allow states or other day care sponsors to continue to apply for and administer funds. Programs funded by other sources, such as CETA and Title XX, could continue to provide supplementary day care programs as they do now.

Additional, and perhaps separate, funding is needed for two aspects of child care provision to migrants: infant care and upgrading of facilities. The greater cost of providing infant care prevents most centers from accepting more than a few infants. Of all age groups, infants are the most vulnerable to the consequences of physical and emotional neglect. Upgrading of facilities is necessary in order to meet licensing requirements. If children are to be cared for in centers that meet the FIDCR guidelines--or any reasonable standards for safety, health, and supervision--additional money is needed to improve or adapt present facilities.

Migrant Head Start is one logical source for initiating a system of administrative and programmatic support. During the course of a year, Migrant Head Start might offer one-time training sessions in each state to all state-level sponsors of migrant child care programs. Such a program would enable all existing sponsors of migrant child care to receive training in the provision of administrative and programmatic support to their respective local migrant day care centers. At the same time, it would set the stage for increased cooperation between the program sponsors for sharing information and resources and for resolving problems of mutual concern.

CHAPTER III

EDUCATION

Migrant children benefit from various school programs during their travels. The Title I Migrant Education program of the Elementary and Secondary Education Act (ESEA) has by far the greatest impact, as its substantial funds are targeted specifically for migrant children. Other beneficial programs include Title I, which complements the special support for children participating in Title I Migrant Education programs; the ESEA Title VII Bilingual Education program under which children of limited English-speaking ability receive instruction in their home language as well as in English; and state-sponsored targeted programs, such as the California Bilingual Education program supplementing the federal Title VII Bilingual Education program in that state.

The review of the literature to this study presents these programs, and selected others, in considerable detail (Porteous, S.M., Migrant Child Welfare, pp. 79-105). For purposes of the field work elements of the study, information was solicited nationwide only from Title I Migrant programs, due to the relatively low level of participation of migrants in other programs. Local Education Agencies (LEAs) operating Title I Migrant Education programs in the target counties were queried regarding their programs, and survey information was obtained from the State Migrant Education Offices concerning statewide programs.

Programs Operated

In the twelve survey states, the Title I Migrant Education program provided educational support for almost 200,000 migrant children in 1975-76. Based on the data available from the survey states, an estimated 40,000 children participated in summer school programs supported under Title I Migrant; 25,000 were provided preschool child care services partially or exclusively funded by the program; and 2,500 participated in secondary level vocational training. Programs in primary home base states were by far the greatest beneficiaries of the program: the Texas program, serving 65,000 migrant children, received $19 million; the California program, serving 34,000, received $18.5 million; and Florida's program, which claimed to serve 42,000 children (although federal records indicated only 32,000) received $12.5 million. The next largest program received $4 million and several received less than $1 million each.

As indicated by enrollment figures, few children in the program benefit from secondary level vocational training under the Title I Migrant Education program: 2,500 enrolled in a population of 200,000. This may reflect the tendency of migrant youth to drop out of school in order to aid family finances through farmwork. A second possible explanation may be that vocational programs have a high per pupil cost. Many schools do not offer such programs; to develop one would require considerable start-up expense and modifications to school policies and procedures. In up-stream states, support of such programs for youth who are only in each area a short time is not seen to be cost-effective. As an unfortunate result, few migrant youth acquire skills, knowledge, or educational credentials that could help them obtain non-farm employment. In addition to the Title I Migrant Education program, however, the High School Equivalency Program, currently funded by the Department of Labor, assists approximately 1,000 migrant secondary students each year.

The largest preschool program is in Michigan, where 7,000 preschoolers are served with Title I Migrant Education funds. (For an extensive discussion of child care programs, please refer to Part Two, Chapter II of this report.)

Summer programs, the most effective educational programs for migrating children, were provided in every state but Florida, which as a home base state has very few migrants during the summer months. These programs are educationally comparable to those operated for migrant children during the regular year, but usually have considerably more flexibility and promote home-school contact through events such as field trips, camping trips, frequent picnics, and fairs. Most programs operate only six to eight weeks; the parents must arrange for child care before and after the summer session. Hours of operation are also a problem. Children are often left unsupervised in early morning hours and after school, when parents are in the fields. Only a few states reported extended day care programs to address this problem. One local level education program respondent indicated that, unlike operators of preschool child care programs, school personnel who plan Title I Migrant programs do not realize their programs serve as a child care facility, since they are accustomed to working with children who go to homes in which the mother is present after school hours. The conditions of most migrant camps increase the danger to the child left unsupervised until his parents return from work. In Vermillion County, Illinois, the Title I Migrant program addresses the problem of program duration. The Title I Migrant program is operated from August until November, and again from April until June during the local farmwork seasons. However, even this program adheres to conventional school hours.

Program Components

Projects operated under the Title I Migrant Education program are designed to supplement basic school programs and basic Title I funding to overcome educational disadvantages which migrant children experience as a direct result of migration and as an indirect result of their low socioeconomic status. The program is part of the Title I Compensatory Education program. LEAs operating Title I Migrant Education programs are already receiving Title I funds to serve migrant children and others as well. Most Title I Migrant Education projects use their funds to hire teacher's aides to supplement the teacher's classroom efforts, primarily by spending more time with each migrant child. In addition, the funds may be used to purchase materials that facilitate acculturation by both the migrant and non-migrant children; bilingual teaching staff are sometimes also hired.

An important element of the federal compensatory education effort is its focus on children's non-academic problems which impede achievement of full academic potential. Primary among these is health care, including dental care, sight and hearing screening, and nutritional supplementation. While data are incomplete for two of the survey states, the other ten indicated that all of these services are available in the Title I Migrant Education programs in their states. The local level arrangements to provide health care through Title I Migrant Education programs are entirely at the discretion of the LEA. Many LEAs contend that their regular health facilities, supported under their basic educational programs, adequately meet the health care needs of migrant children. Until 1976, the Washington state migrant education office required LEAs to prove that their regular health programs were not adequate to meet the health care needs of migrant children prior to approval of any allocation of project funds for health expenditures. In two states, both the education agency and farmworker organization respondents indicated an interest in having the State Migrant Education Office contract with the statewide farmworker organization for the provision of the health components of all Title I Migrant Education projects in the state. This is not known to be the practice in any state yet, although in California an interagency agreement obligates Title I Migrant Education projects to explore the possibility of contracting with a local migrant health clinic (if available) for health care needs before attempting to make such arrangements with any other provider. (Please see Part Two, Chapter IV, of this report for a more extensive discussion of health issues regarding migrant children.)

States were asked about other supportive services provided as part of their Title I Migrant Education programs. (Not all LEAs provided services which the State Migrant Education Office may have indicated were available.) Psychological counseling, outreach and recruitment, career counseling, social worker services, and provision of accident insurance policies were investigated. Information was not available from New Jersey or Colorado on such programs. In the remaining ten survey states, social workers were available. All states indicated that outreach and recruitment were performed but, in some states there are no outreach and recruitment efforts in major migrant areas. Nine states (all but North Carolina, Illinois and Maryland) offered career counseling services. All survey states other than California, Florida, and New York provided accident insurance.

Migrant child enrollment, as determined by the data from the Migrant Student Record Transfer System (MSRTS)--a nationwide computerized system for recording available academic and health records of migrant children--has been the basis for determining funding allocations for the Title I Migrant Education program since 1975.

Outreach efforts have increased nationwide as a result of this per capita incentive system. In Maryland, efforts have been made to identify migrants living in the city of Baltimore. In California and Texas, despite substantial increases in the number of children enrolled through state efforts, state Migrant Education Offices indicated that only about two-thirds of the number of eligible migrant children are currently in Title I Migrant Education programs. In both states, however, the unserved children had been enrolled on the MSRTS; the schools they attended simply chose not to sponsor Title I Migrant Education programs. In Washington, Colorado, and New York, major statewide programs to increase the identification of migrant children have been established. The New York system uses a bi-weekly year-round census of all known labor camps to ascertain the number of eligible children and to alert local schools for prompt enrollment when children arrive in the area. This project maintains charts for each LEA, graphically depicting the number of migrant children enrolled the year before, and when they arrived and departed, so that LEAs can prepare their programs with appropriate timing.

Programs in up-stream states do not usually have former migrants on the project staffs, while those in the home base states do. In several states, the state director of the program is a former migrant.

Although many of the projects offer bilingual/bicultural instruction, this tended to be more common in the home base states. In only one state (North Carolina), was the use in schools of a language other than English specifically prohibited by law. Approximately three-fourths of the responding LEAs indicated that bilingual/bicultural education is a part of their Title I Migrant Education program, although there were low rates of response in California and Texas. According to the responses received, approximately 12,500 children participate in bilingual/bicultural education in these LEAs; data from further research may show an increase in the number of children participating in bilingual/bicultural education.

Nine of the thirty-five bilingual/bicultural projects indicated that their funds were entirely or partially derived from the federal Title I Bilingual Education program. These nine projects, however, included five of the LEAs with the largest Title I Migrant Education programs in south Texas; 87% of the Title VII-served children were in these LEAs. As a result, in the survey counties, more than two-thirds of those participating in all bilingual/bicultural programs were known to be participating in Title VII programs.

Free breakfast and lunch programs, available in all survey states (although not in all LEAs) are provided through funds from the U.S. Department of Agriculture. Several advocacy agencies had attempted to urge non-participating schools in their area to provide breakfast service.

Parent Participation

Five of the survey states maintain state-level Parent Advisory Councils (PACs) made up of representatives of the local PACs, to advise on state program operations and be involved in the development of the annual state Title I Migrant Education program plan.

There is a great difficulty in the up-stream states in recruiting migrant parents to serve on local PACs as migrant families are in the area only a short time and the demands of farmwork leave little free time for other activities. Most programs compensate for this by having non-migrant local parents who are already members of the school's PAC for the Title I Compensatory Education program serve on these committees. In some cases, however, stronger by-laws have been adopted which require 51% migrant membership on a migrant program's PAC. In one Maryland town, the migrant PAC meets just before the farmwork day begins at 4:00 a.m.--the only time available. California has eight Title I Migrant Education program regions, each considered an LEA by the state. California regional PACs are quite strong. At least one takes part in the screening process when staff are hired for the migrant program and has a requirement that all staff hired for the program must be bilingual.

In several cases, attempts exist to involve the migrant parents outside of the formal mechanism of the PACs. School/family events in the summer programs have been mentioned above. In several projects, migrant parents who are not working in the fields become teacher's aides or homeroom mothers. Some schools sponsor evening sessions in the camps to provide basic education for adults which benefits both parents and the children in the program.

Family Perceptions of Education Programs

The complexity and variety of projects operated under the Title I Migrant Education program complicated efforts to determine whether children of the migrant families interviewed were participating in special programs in their schools. The survey questions were worded so that only the current programs in which a child might be participating were discussed. Information was collected in September and early October of 1976, and some families may not have had their children enrolled in school at that time. Those in school may have been there for too short a time for parents to have found out what programs were being provided.

According to statistics from Migrant Branch of the U.S. Office of Education, there are an estimated 600,000 school-aged migrant children in the United States eligible for Title I Migrant Education, but only 400,000 currently benefit from programs. In fact, one-half of the survey families indicated that their children were not receiving special programs, although they may have been unaware of the Title I Migrant Education program even if their children were enrolled in it. Many of the parents did not perceive a need for special programs for their children; fewer than one-half of the parents surveyed perceived that their children had compensatory needs. Although tutoring or small group/individualized instruction is a main component of most Title I Migrant Education projects, only slightly more than one-seventh of the children surveyed were being taught by those techniques.

Some differences were noted in educational services received in-stream vis-a-vis home base. Two-thirds of the children reportedly received special programs at home base, compared to more than half in-stream. Almost one-quarter of the children received services at both in-stream and home base areas. Parents' understanding of what constitutes a special program varied widely.

More than one-half of the children participated in free breakfast programs at home base, and three-quarters received free lunches. In-stream, slightly more received breakfast, and the number receiving lunch was slightly less.

Less than one-eighth of the families indicated that problems with schools were impediments to raising children at home base; the number was slightly less for those in-stream. In both cases, education was the third most frequently cited child-welfare-related problem, following housing and day care availability. However, when asked about new services desired, requests for educational reforms accounted for less than one-seventh of the responses.

One indirect indicator of the differences in the makeup of the three migrant streams in the country was the responses to the above questions by stream. Slightly less than half of the parents queried felt their children needed special educational services. However, two-thirds of those in the West Coast stream indicated this need, compared to only two-fifths in the East Coast stream, which has always had a greater number of single workers without children (and until lately was predominately comprised of Blacks, whose children might not have the difficulties of language translation in school). More than one-half of the families had children who received free breakfasts in school. Forty percent of those in the west, 50% of those in the central stream, and 60% in the east answered affirmatively when asked whether their children participated in the free breakfast program. The west also had the lowest proportion of children receiving free lunches in schools. For any nutrition services in any location, the greatest percentage of families who benefitted was only three-fourths, indicating a potential minimum 25% unmet need.

Findings concerning differences between migrating families and those who have settled-out of the migrant stream were ambiguous. A similar proportion in each group (about 40%), indicated that they felt their children needed special educational services. Slightly more than half of the settled-out families indicated their children received free breakfasts in school, compared to just half of such children in currently migrating families. Over two-thirds of the settled-out families' children received free lunches in school, compared to three-quarters of those currently migrating. Thus, while in most cases children did receive free meals in school, nevertheless, more families' children received free lunches than free breakfasts, and many more migrating families' children received free lunches compared to children of the settled-out families.

Problems with schools were cited one-eighth of the time by migrating families. Settled-out families mentioned this problem only half as often and cited the need for educational reforms fewer times than did currently migrating families. (For detailed presentation of the information obtained in the family interviews, please refer to Part Three of this report.)

Program Characteristics and Problems

A large national program designed to meet many different needs in many different settings, the Title I Migrant Education program funds many projects which innovatively approach their local situations. In the recent book, *Promises to Keep*, the National Child Labor Committee points out the mandate of the national Title I Migrant office is to improve the program through identification and dissemination of successful innovative techniques useful in working with migrant children. Even state offices may not know of valuable innovative developments. Dissemination is vital; otherwise the effectiveness of these programs, and their contribution to migrant education is diminished (National Child Labor Committee, *Promises to Keep: The Continuing Crisis in the Education of Migrant Children*, New York, New York: National Child Labor Committee, 1977, p. 31). Federal law establishing the program requires that the national office actively should pursue this role, but it has not complied. The national office has a staff of only eight professionals, whose time is almost entirely spent in the basic administration of the program. Development and establishment of a national clearinghouse for migrant education program concepts could be useful. The lack of information dissemination, along with poorly coordinated evaluation procedures throughout the Title I Migrant Education program, has resulted in a large federal effort in which there is "... no detectable relationship between per capita expenditures and program quality" (NCLC, *Promises to Keep*, p. 32).

The NCLC report and other documents have found major faults with the Title I Migrant Education program, including misuse of funds, lack of coordination, unclear regulations, and a reluctance to bypass grantees not in compliance with program guidelines. Much of this information can be found in the review of the literature for this study (Porteous, S.M., *Migrant Child Welfare*, pp. 86-93).

The Migrant Student Record Transfer System

For the past several years, with funds derived from state allocations, the Title I Migrant Education program office in the U.S. Office of Education has supported the development and implementation of the Migrant Student Record Transfer System (MSRTS), designed to facilitate the transition of migrant children's records from school to school. This system consists of a central computer operated by the Arkansas Department of Education, approximately 155 terminals, and experienced terminal operators around the country who participate in a two-way information retrieval process. The computer registers both academic and health information for migrant children. At an annual cost of slightly less than $2 million, the system maintains this information on 400,000 migrant children. Each school enrolling a migrant child can request, through the nearest terminal, a copy of the child's record; a short copy can be sent directly to the terminal by the central computer and a longer record is available by mail if needed. Thus, the receiving school can identify the child's educational achievement level and health needs, and provide appropriate educational support and referral.

Unfortunately, the program is not effective, according to more than one-half of state and local level education agency respondents.

Two main problems exist. First, in order to have information on a child in the computer, the home base school must take the extra time to submit to the MSRTS the necessary forms on each child who will be migrating. This burden is borne in part through funding MSRTS record clerks in the Title I Migrant Education program's allocations to home base schools. The added paperwork is considered by the schools to be an inconvenience particularly as it is expected to be accomplished at the very beginning of each school year. As a result, it is often not completed. A MSRTS clerk at one LEA responded with some impatience concerning this problem:

> "We cannot afford the personnel it would take to do what is asked. We cannot send a community aide to each home in the first weeks of school to make sure each form is printed, or sit at a desk printing information that is already on the computer form. In most cases the only time the classroom teacher sees the form is when she is putting information on it she already knows. The computer idea is all right, but why can't it work for us instead of us working for it? The MSRTS has gotten so big that school districts are having to hire personnel that do nothing but work on it. The end result does not justify the money taken away from the classroom."

Thus, many children who migrate do not have forms on the system that describe their achievement during the months they were at home base. Many up-stream schools commented that there is frequently no other information on a child's form than that which they themselves recorded onto it the previous year when the child was in their school. This means that the home base schools are not the only schools failing to record as well as request information.

The other primary flaw with the system is twofold: the records are sometimes of no use to the receiving teacher even when information is recorded from previously attended schools because by the time the printout has been received, the child has already been tested and appropriately placed--or moved on. Also, the existing categories for recording educational achievement are so broad as to be of little use to the receiving teacher. A team of state Title I Migrant Education program directors has been working with the national office to develop an improved form, but, as the NCLC points out, more than twenty different tests of basic educational achievement are used by schools which serve migrant children in-stream. The results of the many locally developed intake tests have questionable validity when a child has been tested every few weeks in a new setting and under unknown language and cultural handicaps. Attempting to standardize objective achievement measures for the use of teachers in many different districts may be futile (NCLC, Promises to Keep, p. 20).

Inadequate recording of base information and inutility of records seriously encumber the value of the system. Many respondents indicated that, considering the amount of work, cost, and ineffectiveness of the system, it should be discontinued and the funds used to improve health care and other supportive services of Title I Migrant Education projects. Nevertheless, a substantial number of respondents felt that the system had potential and should be continued.

Coordination

Another major need is improved coordination at all levels in the Title I Migrant Education program. Considerations affecting the autonomy of local LEAs in arranging for health care and the lack of any guarantee that special health care needs can be met have been discussed above. The coordination of farmworker organizations, migrant health clinics, and other advocacy groups for improved identification, recruitment, referral, and program development is very important. Extending day care arrangements through the use of pooled resources could be one benefit of improved coordination. Constant efforts to improve contacts between the schools and the families of the migrant children is also needed.

State-local coordination is equally critical. Equitable utilization of funds, along with awareness and use of agency linkages, depends on frequent and comprehensive information exchange between the SEA and the LEAs. The state office is empowered to award funds to agencies other than the local school districts if they decline to operate Title I Migrant Education programs. Careful and sustained monitoring of programs, migrant needs, and the relative capabilities of the school districts vis-a-vis other providers in the state are necessary to invoke this authority.

Federal-state and federal-local coordination should be exercised through comprehensive reviews of annual plans and well programmed visits each year to the state agency. Dissemination of successful models and monitoring of projects are both necessary for coordinated program assessment. However, data do not exist to permit effective assessments. The last evaluation of the program, made during the 1972-73 school year, found that "Student progress cannot be adequately assessed at the national level, because of lack of guidelines and uniformity in evaluating procedures.... There is no unified and coordinated national approach to needs assessment of migrant children." (Exotech Systems, Inc., Evaluation of the Impact of ESEA Title I Programs for Migrant Children of Migrant Agriculture Workers, Vol. I, Falls Church, Va.: Exotech Systems, Inc., 1974, p. 3.) Although one-half billion dollars have been spent on the Title I Migrant Education program since 1973, these conditions persist.

Coordination within the federal government is also necessary. Programs such as Migrant Head Start, Title I Migrant Education, Migrant Health, Migrant Vocational Rehabilitation, and Migrant Hospitalization could, through federal coordination, develop concentrated demonstration projects to show the efficacy of locally coordinated programs with simplified intergrantee funding and eligibility determination. These programs all operate in relative autonomy at present, although solutions to the problems of the migrant population require comprehensive, coordinated approaches. The Community Services Administration (CSA), authorized to coordinate federal programs serving migrants, and the Department of Labor's Migrant Division, similarly do not interact formally with the above program sponsors.

Conclusion

Migrant children are usually in a school too briefly to become known personally by the teaching staff, and to permit much instruction or measurement of achievement gains. The children of migrating families are often from cultural backgrounds greatly dissimilar from local resident children, yet their academic performances are evaluated by local standards. The typical participating school is usually not equipped to provide for all migrant children's needs. Assuring the educational development of such children cannot be considered the responsibility of any one school or district, because migrant children enroll in so many different schools. Although states shoulder a greater portion of the responsibility, they cannot be held accountable for the education of individual children who migrate thousands of miles annually. The federal government supplements the funding activities of states but provides very little direct education. Thus, no single level of government is charged with the responsibility for a migrant child's education.

Local schools need assistance in meeting the needs of migrant children whom they enroll for relatively short periods of time each year. The Title I Migrant Education program supports these schools in addressing the need, but the extent to which this support enhances the migrant child's development varies greatly among schools. Autonomous state administration of migrant education programs designed to serve a mobile, national population is inappropriate; federal authority for direct program monitoring should be increased. Additional federal intervention is needed in ensuring equitable allocation to and within states, assessing appropriateness of supportive services, assisting in coordination with other federal programs, and disseminating information on successful models to turn ineffective programs into effective ones. The MSRTS should be funded on a scale that can completely eliminate the burden it now places on the schools it was designed to serve. If this is not possible, the MSRTS should be eliminated, and the good judgment of local school personnel be relied on. A framework of increased monitoring of program operations by substantially augmented federal and state program evaluation staffs would complement this alternative approach to continuity of education.

Clear policy decisions need to be made concerning the relationship among the following programs: Title I Migrant Education preschool care, Migrant Head Start, Head Start, Title XX child care, and the Day Care Services program within the Office of Child Development. The federal programs which are available to migrants from birth through career employment should be coordinated, available, and known to all who need to use them.

CHAPTER IV

HEALTH

Medical technology has advanced so rapidly in the past few decades that illnesses and physical conditions which would have resulted in severe impairment or death a few years ago are now often diagnosed early through routine screening and treated, resulting in improvement in the patient's health. However, while the health care standards for those who can afford good medical care are quite high, there has been little change in the health care standards of the poor.

The rural poor are the most medically underserved group. Fewer physicians are willing to serve in rural areas and they are seldom as well trained as urban physicians. Isolated from universities and medical centers, rural physicians do not have access to ongoing professional development. Attracting and keeping qualified medical personnel in rural areas is an extremely difficult problem, and there are various incentives available through special programs to alleviate the situation. Unfortunately, funding for these programs is inadequate to meet the existing need for health care.

Of all groups in our population, migrants are the most difficult to provide with health care. They travel frequently and are not aware of local services, so outreach must be provided by health centers. They often do not have their own transportation, so transportation may have to be provided as well. They may not be able to leave work to take their children to a doctor, so extended clinic hours may be necessary. Many migrants are also of limited English speaking ability and need bilingual personnel to translate their health problems to monolingual professionals. Many migrant families seek health care from non-traditional sources. Health personnel serving migrants need to be aware of cultural differences in order for health treatment and education to be effective. All of these factors must be considered in health delivery to migrants in addition to those problems that they have as a sub-group of the rural poor.

Comprehensive preventive care and treatment, including health education, are essential if migrant parents are to remain well and able to provide for the health needs of the family unit. The health problems of migrant children are often common ones: poor teeth and vision, gastro-intestinal difficulties, upper respiratory infections, and ear infections. The treatment for these illnesses is known. The difficulty lies in assuring that migrants have access to health care. In one California clinic, personnel estimated that about 75% of the need for health care went unmet.

Services

Providers of health care to migrants were interviewed in the target counties of the twelve survey states. The services commonly provided include immunizations, physical examinations and screening, the WIC nutrition program,

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prenatal and dental care. Specialized disease testing and health education were offered less frequently.

While comprehensive care is usually the domain of migrant health grantees, some preventive services such as immunization and screening for communicable diseases are available for migrant children through county health departments. Additionally, migrants may benefit from prenatal care and the Women, Infants, and Children nutrition program (WIC) provided by county health departments in some states. Services of migrant clinics and health departments are supplemented in some cases by Visiting Nurses Associations and, in some eastern stream states, by the East Coast Migrant Health project. It is difficult to ensure that all migrant children benefit from these health services. School-aged migrant children who are enrolled in Title I Migrant Education programs and who attend regularly are, at most schools, provided with health diagnosis and treatment in conjunction with the academic programs. However, school attendance of migrant children decreases markedly after age 12. In addition to receiving no further academic work, older children who are not in school lose the benefit of easy access to routine health care.

Providing health care to preschool children is also difficult, and the need for timely health care is even greater. Many diseases and conditions which develop in childhood can be successfully treated if they are detected early. Access to health care services is provided to those children who are in day care programs. All the major child care funding sources--Title I Migrant Education, Migrant Head Start, Title XX, CETA, and State migrant day care programs--allot funds for health care.

For the 50,000 to 75,000 migrant children in the twelve states who are not enrolled in day care programs, receiving health care is dependent upon either the parents' knowledge, initiative, and ability to transport the children to clinics or upon the outreach efforts of the health providers.

Immunization

The most widely available health care service is immunization, reported by respondents to be available in all twelve states surveyed. The need for immunization against communicable diseases continues to be critical. In 1973, the United States Center for Disease Control reported that one in three preschool children were not receiving full immunization against diphtheria, pertussis, measles, and polio myelitis. (U.S. House of Representatives, Ninety-fourth Congress, Second Session; Committee on Interstate and Foreign Commerce, Subcommittee on Oversight and Investigations, "Department of Health, Education and Welfare's Administration of Health Programs: Shortchanging Children." Washington, D.C.: U.S. Government Printing Office, September 1976, p. 2.) The proportion of children unprotected against such diseases is increasing. More recent estimates indicate that as many as four in ten children are not fully immunized. Providing physicians with current medical histories for migrant children is extremely difficult due to migrant mobility. There are some additional record-keeping problems if day care providers do not use the same health care provider consistently. In one state where a day care project reportedly arranged for the children's physical examinations to be conducted by a private physician for a fee lower than the migrant clinic's standard fee, clinic personnel subsequently expressed concern when it resulted in the clinic's health records being neither utilized nor updated. The consequences may be serious if children are treated for an illness or condition when the health history is unknown or unavailable. However, immunization is one area of prevention in which the advantages of ensuring adequate protection far outweigh the possible risks of over-immunization. The risks to the child of non-immunization depend on the incidence of the disease where the child lives. Measles is still common, and if a family member contracts the disease, the child has an 80% to 90% chance of also contracting it. Polio, now rare in the United States, is more common in Mexico. Greater care should be exercised in immunizing children who live near the Mexican border even for part of the year. Diphtheria, pertussis, and tetanus are also still considered serious threats to children. A spokesperson for the Center for Disease Control recommended that if there is no knowledge of previous immunization, vaccination by medical personnel is strongly indicated for children. (Hayden, Gregory, M.D., USD/HEW Center for Disease Control, Bureau of State Services, NIH, Rockville, Maryland, personal communication, May 1977.)

The knowledge that the risks to children from over-immunization may be small should not prevent the refinement of existing health referral systems since follow-up and continued treatment for an illness are essential. Such systems are discussed further in the section on Program Implementation, below.

Physical Examinations and Screening

Physical examinations and routine screening are available in all target counties. The diseases for which screening is provided vary from state to state. In Iowa, children were screened for TB. The New York county health department also provided TB testing and, to a lesser extent, sickle cell screening. The county health department in Washington screened for typhoid and shigella.

Respondents indicated that it can be difficult to perform physical examinations and screenings for all day care and school-aged children during the operation of the summer programs. In at least two of the states, health providers use mobile clinics to help meet the heavy summer need. Through the coordinated efforts of several agencies and organizations in Colorado, funding was obtained in 1976 for a mobile health team. This team, headed by a pediatrician from the University of Colorado, was staffed by medical and dental students. The mobile unit visited each health center which served migrants. The staff offered their direct services to migrants and their consultation to local clinic staff. The program was rated highly successful by everyone who had observed it in operation. Although first year funding was provided through a grant, the Colorado Coalition of Agencies is seeking state appropriations to continue the program. The migrant health clinic in Washington also provides a fully staffed and equipped mobile unit to conduct health screening throughout the Yakima Valley. Both of these programs increase the accessibility of preventive health care to migrant children.

In the target counties of seven survey states, health providers reportedly offer specialized disease testing for migrant children as follow-up, based on the information provided by physical examinations.

Nutrition Supplementation

One of the basic methods of maintaining children's health and strengthening their resistance to illness is through adequate nutrition for children and for pregnant and lactating women. The Special Supplemental Food Program for Women, Infants, and Children (WIC) is designed to help meet nutritional needs in high-risk populations. (Porteous, S.M., Migrant Child Welfare, p. 18). Migrants qualify for the program, using WIC food supplements if offered in the area where they are working, and if slots are available. Nine of twelve survey states provide the WIC program in the target counties, four through migrant health centers and five through county health departments. In some cases, the slots may be filled before migrants arrive, although some states reserve slots in an attempt to ensure service for migrants. In at least one state (Michigan), the number of reserved slots was insufficient for the number of families needing nutrition supplements. The success of the WIC program is heavily dependent upon effective outreach to families. As of April 1977, a portion of the WIC administrative funds can be used for outreach to camps and other homes. Health clinics also advise their patients that they are potentially eligible for the WIC program.

Some very basic preventive care is provided apart from the health centers. Both schools and day care programs provide free meals, usually breakfasts and lunches. For many migrant children, these meals are the only balanced meals they have. Although applying for these programs is simple, one migrant mother reported a ten-day time lag before her children began receiving food.

A surprisingly low percentage of migrant children received free breakfasts in school or day care programs. Only 51% had free breakfasts in home base and 56% in-stream. More received free lunches: 74% in home base, but only 69% in-stream. Reasons for the relatively low participation in the program were unknown.

Dental Care

Some dental care is provided in each of the counties surveyed. Migrant clinics were the providers in all states except Maryland and Texas, where the county health departments serve migrant patients. In California, Colorado, Florida, New York, and Washington, dental programs were extensive enough to have a substantial impact on dental health of migrant children. The dental clinic in Imperial County, California, provides dental services with three full-time dentists and a dental surgeon who is available one day a month. Respondents indicated that despite the staff size dental needs of many migrants were not met. In Colorado, dentists at one of the Weld County clinics examined and treated 80 to 100 children during the summer of 1976. At the end of the season, much of the needed work was unfinished when children left the area. Dental staff in the Collier County, Florida, project served an estimated 2,000 migrant children during fiscal year 1976. In New York, the dental program was quite large and the staff were able to reduce the appointment time to two weeks for all patients. The Washington program, unusual in that it is state-funded, provides free dental care to all migrant children up to age 12.

In the other seven states surveyed, the programs were only minimally serving migrants' dental needs, with the result that a large percentage of migrant children in those states are without adequate dental care.

Health Education

Health care providers indicated that health education was available to migrants in seven of the states. The quality of these programs varies widely with the provider. In California, one of the field nurses employed by a county health department is a health educator. The health education program of the migrant health project in Iowa offers information on preventive health care in nutrition, dental care, family planning, child care, personal hygiene, and sanitation. Some of this information is presented to patients in the clinic waiting room through the showing of educational films. In the clinics or health departments in which the WIC nutrition program is offered, there is opportunity for the inclusion of nutrition education for program participants. The educational aspect is mandated to be a major focus of individual WIC programs.

Health education is one of the most valuable forms of preventive care. As migrant parents and older children understand the factors which are related to the prevention of illness and disease, they can begin to implement health procedures within poverty conditions. In addition to formal presentations, health education can be an integral part of any medical visit by a migrant family. Many migrant families indicated that after a visit to a clinic, they were unsure of the diagnosis or the treatment prescribed. Both nurses and doctors have an obligation to ensure that migrants understand the nature of their own and their children's illnesses. Several agency respondents in Colorado expressed their admiration for the personal attention afforded migrants during the screenings by the mobile team. The personal manner of the staff and the adequate explanations of medical procedures and treatment contributed to migrants' better understanding of health care and increased willingness to use the clinic.

Hospitalization Insurance

Although reimbursement for migrants' hospitalization costs was reported by health care providers to be a great problem, there are two programs operating in the states surveyed which attempt to meet the need for hospitalization insurance. The East Cost Migrant Entitlement Project (ECMEP) serves approximately 2,000 Florida-based migrants, 800 of whom are less than 16 years old. The project provides migrants with complete health care, including hospitalization, in Florida and states up-stream as far as New York. Insurance is arranged through a contract with the Florida Blue Cross/Blue Shield program, and supported by a grant from the Bureau of Community Health Services (BCHS). Hospitalization costs for migrants in one Colorado local hospital are covered through funds received under the Migrant Hospital Demonstration Program, funded since 1973 by BCHS. Funds have been reduced recently and now cover only a fixed number of patients. Such programs, although providing coverage for essential services in the areas where they operate, do not begin to meet the need for hospitalization coverage nationwide.

Funding

Funding for health services to migrants in the selected counties of the twelve states studied is primarily through the Migrant Health Act (MHA). (Porteous, S.M., Migrant Child Welfare, p. 14). MHA funds are utilized in all twelve states and many of the projects successfully sought additional funds from other sources. These funds generally enabled projects to serve a broader based population, or added specific program components. Projects in seven of the states used public health monies which include federal funds. In nine states, WIC funds were used to provide the special nutrition program. Other federal sources mentioned less frequently were the Rural Health Initiative, Health for Underserved Rural Areas, Family Planning, Maternal and Child Health, National Health Service Corps, Bureau of Health Insurance, and the National Institute on Alcohol Abuse and Alcoholism. Many child health service providers are reimbursed by third-parties such as Title I Migrant Education, Migrant Head Start, Title XX, state day care programs, CETA, and EPSDT. There are also additional funding sources from contracts with employees and fees for service. Local health projects serving migrants were supported in some states by the United Way, Community Action Program, and other donors.

Direct Federal Funding

The Migrant Health Act has been the mainstay of health care for migrants, providing health care where migrants' non-resident status precluded their receiving state-supported health services. The program provides grants to public and private non-profit agencies, organizations, and institutions to establish family health centers for "domestic agricultural workers and their families...and conduct special projects to improve health services and conditions." (Schmitt, Raymond, "The Migrant Farmworker

Situation in the United States: The Problems and the Programs." Washington, D.C.: Congressional Research Service, Education and Public Welfare Division, 1975, p. 37). Priority for funding migrant health programs is given to areas with the highest concentrations of migrants residing for more than two months of the year. Applications are ranked according to number of migrants and the length of time migrants reside in the area. This reflects the judgment that migrants who are in an area for longer than two months will have greater need of health care.

The prioritizing of health care needs is evident in the whole range of federal programs which are possible funding sources for migrant projects. Within the Bureau of Community Health Services, the resources of four programs have been integrated in an effort to develop county/community primary care systems in rural areas with critical health manpower shortages. Four programs are now integrated under Rural Health Initiative (RHI): the Community Health Centers Program, Migrant Health, the Appalachian Health Program, and the National Health Services Corps.

The priorities of RHI are essentially a combination of the priorities of the individual programs with additional consideration for areas of high infant mortality. The broad funding priorities are for those areas which have a critical health manpower shortage, high migrant concentrations, or a high infant mortality rate. Although RHI funds for individual projects are limited to $200,000, they enable projects to maximize the use of health resources by serving a broader population. Thus, migrant health projects, serving only migrant and seasonal farmworkers and their families, may apply to RHI for funding to open clinics' services to the community. Additionally, community health projects may apply for funding to add a migrant component or to add National Health Service Corps personnel.

Although funds are still available from the categorical programs, projects are encouraged to consider increasing their service population through the use of additional funding.

Another federal funding source utilized by one health care respondent is Health for Underserved Rural Areas (HURA). This is a relatively small source which consists of funds for research and demonstration projects. HURA funds, appropriated in 1975 for five years, are administered by the Public Health Service. These funds require linkage with other service and research programs.

Funds for the WIC nutrition program are arranged through the Food and Nutrition Service (FNS) of the Department of Agriculture. This source is currently used in nine of the states surveyed.

There are other health funding sources which could potentially provide additional income for migrant health projects. However, there are still difficulties which must be overcome in order to use these funds to provide services to migrants. These difficulties are mostly eligibility-linked and constitute the basis for the original development of targeted migrant health programs through the Migrant Health Act. While the eligibility issues remain unsolved, the funds may still be tapped, enabling migrant clinics to expand services to non-migrant clients.

Funds from Maternal and Child Health (MCH) are currently being utilized by only one migrant health center in those counties of the twelve-state sample. However, these funds are the basis for much of the preventive care offered to all low-income mothers and children at county health departments. Such preventive care includes administering special projects to provide health services to particular groups of mothers and children who would otherwise not receive them.

There are difficulties in securing for migrants the services provided by these programs. Migrants are generally income-eligible for all of these services provided by county health departments. They may, however, be denied service because they cannot prove intent to reside. The problem of state-defined eligibility is encountered in nearly every federal program requiring state matching funds, although federal regulations provide that there can be no residency requirements and families may apply for service immediately upon arrival. Federal Maternal and Child Health personnel indicated that state plans will not be approved at the regional level if there are any residency requirements. However, there are no federal regulations to prevent states from asking recipients of service to provide evidence of an "intent to reside." Although federal and regional MCH personnel indicated they had no knowledge of such state requirements, in at least one state in the survey, migrants are not provided services with MCH funds because of a technical residency requirement. Similar requirements govern the actual use of other federal/state programs such as Title XX and Title XIX (i.e., Medicaid, which currently includes EPSDT for children).

Since these factors may inhibit service delivery to migrants at county health departments, it seems reasonable that migrant health clinics might apply for MCH funds directly. Applications for service funds must be made to state health agencies; this procedure may be a handicap to migrant health centers. Research and training grant applications for MCH funds may go directly to the federal level, thus increasing the probability of funding.

Although it is possible to secure MCH funding, the difficulties involved for migrant health clinics in obtaining and administering the funds are formidable. Rural Health Initiative appears to be a much simpler route for migrant health programs to expand their services and client populations.

Fees: Third Party Reimbursable and Fee-for-Service

Many of the health care services provided in a migrant health center or community health center may be reimbursed through health coverage provided by a day care or school program. Generally, health diagnosis and treatment, and to a lesser extend dental care, are provided for all children enrolled in the program, including preschoolers, and are covered by Title I Migrant Education funds.

Health care coverage is also provided by the other major funding sources of child care for migrant children. Services such as physical examinations, screening, and treatment may be provided for those children served by Migrant Head Start, Title XX, state day care programs, and CETA. Day care providers indicated that such health services were paid for by the day care funds. Generally, the day care center nurse provided some care, with complete physicals and other treatment performed by physicians at health care facilities.

Payment on a fee-for-service basis for those children eligible for Medicaid coverage is another potential source of income for migrant health centers. Unfortunately, as indicated above, residency-linked eligibility requirements may exclude migrant children from coverage for Medicaid programs, such as the Early, Periodic, Screening, Diagnosis, and Treatment program. However, agency respondents in only four states (New York, Texas, Washington, and California) indicated they offered the EPSDT program, or similar state-funded programs, to migrant children in the target counties.

There is a broad residency definition for purposes of Medicaid eligibility. The federal intent is that migrants should be included in Medicaid benefits. In practice, the federal definition is interpreted differently by different states. The actual decision of whether a migrant is eligible may be made by an individual caseworker. In order to limit the number of possible interpretations, the federal Medicaid office is expected to issue new guidelines defining a resident for the purposes of Medicaid after August 1977.

In addition to the residency problem, in most states eligibility for Medicaid, including EPSDT, is linked to the Aid to Families with Dependent Children program (AFDC) and AFDC families are guaranteed Medicaid benefits. However, families which are as medically needy as AFDC families but which do not meet the AFDC "family configuration" do not often receive Medicaid benefits. This usually means that families with two parents who are able to work are ineligible. Federal regulations have always contained an option for states to provide Medicaid benefits to all medically indigent people, basing eligibility solely on income without considering family configuration. However, only sixteen states have chosen to extend Medicaid benefits, and thus EPSDT, to all medically indigent people. Of those states surveyed, California, Maryland, Michigan, New Jersey, and New York have extended Medicaid.

Legislation for an EPSDT program revision, under consideration in the 95th Congress, would invalidate the "family configuration" criteria in all states for children under six years of age. Under the Child Health Assessment Program (CHAP), coverage would be expanded so that all medically needy children under six years would be provided with EPSDT solely on the basis of their families' level of income. Also, the period of eligibility would be extended for six months after eligibility for medical assistance would otherwise have ended. This means that many migrant children under six, who generally travel with both parents, could benefit.

Although all the services provided for and payable under EPSDT/CHAP can be provided by migrant health clinics, greater EPSDT/CHAP coverage would certainly help to insure that the services were provided to the children and would help migrant health centers to make the maximum use of funds.

Another source of income for health facilities which serve migrants is contractual services. In some areas of California, growers provide their employees and families with health coverage through contracts with local migrant health centers. United Farm Workers also has a prepaid health plan for members. Other sources of income include fees-for-service, which are generally on a sliding scale for those patients ineligible for free services on the basis of income, and contributions from Community Action Programs, the United Way, and other local donors.

Whether migrant health centers are able to utilize money from a variety of sources depends to a large degree on their ability to generate state and local support. The funding sources discussed above are those which migrant health centers have used, and do not represent an exhaustive search of all available funding sources.

Program Implementation

The administrative structure of health programs which serve migrants varies widely among the programs contacted in the twelve survey states. Each migrant health project is operated somewhat differently, and even projects within a state are not always administered similarly. In almost half of the states surveyed, programs carrying the responsibility for the provision of health care to migrants are separate from those of the health department. Health departments in some states encourage migrants to use the preventive services offered. However, in other states, the health departments refer all migrants to the migrant health program.

In states where the migrant health programs are components of larger health care projects, they operate either in conjunction with the county health department or as a party of a community-based health project. The move toward community-based projects represents a federal policy shift within the area of rural health. Short-term comprehensive services such as those needed by migrants are very difficult to operate.

Rural populations are the most underserved in the country. There is a shortage of staff, the level of staff training is frequently less vigorous than the urban counterpart, and there is a shortage of facilities and equipment. Therefore, when projects are established which serve only migrants, the problems of health care delivery for all rural poor are exacerbated. If existing community health projects apply for funding to extend services, the interests of all the rural poor will be better served through the maximum use of health care resources. Migrant health care as a separate component will not be decreased in effectiveness. Federal health personnel recognize the necessity of special provisions for migrants to ensure accessibility to health care programs. The federal Migrant Health Program is retained as a separate funding source with a portion of its appropriation allotted to the Rural Health Initiative, a coordinating body for four rural health programs. Personnel from each of the programs work together to ensure that individual projects make maximum use of the appropriate funding sources. Projects are encouraged to submit applications which indicate how the project will be coordinated with existing health programs. In this way, the needs of the rural poor are met more effectively without sacrificing the quality of health care delivery to migrants.

Further assurance that migrant programs will continue to meet the needs of migrants is contained in the Migrant Health Act which stipulates that a governing board shall have a majority of members who represent center clientele in demographic factors, such as race, ethnicity, and sex (Federal Register, "Grants for Migrant Health Services, Interim Regulations", Vol. 41, No. 178, Washington, D.C.: U.S. Government Printing Office, 1976, p. 38894).

Generally, it is agreed that the greater the degree of coordination between existing health care providers, the more effective the service delivery to migrants. For temporary residents who have transportation difficulties, coordination of health care programs with other available programs can contribute greatly to increased utilization of necessary services.

The extent to which the coordination is implemented differs from project to project. In some areas, there is evidence of pooling of resources by the staffs of programs which serve migrants. Colorado has effective coordination among services, achieved at both the local and state levels. Outreach and referrals are coordinated among the health care providers, the Title I Migrant Education programs, and farmworker organizations. In California, a group composed of directors of the migrant clinics coordinates rural health services. However, in some cases, the efforts of migrant health projects are not well coordinated with those of other health providers in the same area. In New York, the nurses who provide outreach and service to migrants in the target county are directed from the regional health office, and do not coordinate with the County Public Health Nursing Service.

Other types of linkages which innovative migrant health clinics have established include arrangements with local universities. In Iowa and Colorado, medical and dental students have helped to staff health care projects. In both instances, the response from permanent staff and patients was positive. Often, attempts at coordination of service delivery fail because of conflicts between the staffs of the various service providers or because staffs defend their own program priorities to the detriment of integrated migrant program development. Those staff members who have succeeded in establishing not only a formal mechanism for coordination, but also an actual cooperative relationship are to be commended. It is a difficult task for staffs which are generally already overworked.

There are several projects in operation which attempt to address the need for continuity of health care. The Migrant Student Record Transfer System (MSRTS) of Title I Migrant Education provides health forms which accompany a child's academic information. The nationwide system only includes information on enrolled children. Information can be retrieved from computer terminals by each school the child attends. Another system, the National Migrant Referral Project(NMRP), serves all migrants in the mid-continent and eastern streams. This system alerts the health care providers if follow-up care is needed by migrants moving into that area.

A third system is used by the East Coast Migrant Head Start Project (ECMHSP) which attempts to provide total health and development continuity for the children they serve through records retained at a central location in Florida and through parent education. Educating parents in the necessity of maintaining health records was the most effective means used by the ECMHSP staff to provide continuity. Consequently, parents assumed more responsibility and carried health records with them.

Although many factors influence the accessibility of health care to all rural poor population groups, the effect on migrants' access to care is critical because of their mobility, their language and cultural differences, and their isolated living conditions. Migrant clinics provide access to the degree which they provide staff of similar cultural background who are bilingual (Spanish or an Indian dialect), outreach to camps, extended clinic hours, transportation to the clinics, and referrals between agencies.

Many of the projects surveyed in Colorado, Florida, Iowa, Texas, and Washington utilized the services of former migrants in various capacities. Even more of the projects employed bilingual personnel, while in California and Texas, most of the personnel are bilingual. Several bilingual people are on project staffs in Florida, Illinois, Maryland, and Michigan. However, a newly opened clinic in North Carolina had only one bilingual person to act as an interpreter. In New York state, local difficulties due to a lack of bilingual personnel were reported.

Outreach was provided by health care providers in all twelve states. Generally, the migrant clinic staff provided the outreach, but in some areas, such as New York state, nurses funded by the Visiting Nurses Association worked with migrants in a separate outreach project. While the effectiveness of outreach varies and some projects do an excellent job of coordinating outreach with other service providers, usually good coordination avoids duplication of efforts and ensures that all migrant families are informed of services.

Extended clinic hours are an essential feature of health care provision to migrants as migrant parents cannot afford to take a day off from their work to go to a doctor unless an illness is serious. Evening clinic hours enable them to take advantage of preventive care. In nearly all of the target counties, clinics were open during some evenings. Special screenings for children were provided and specialists were available for consultation.

Since many migrants do not have their own transportation, this service must also be provided to enable migrants to use the available health care. In many of the target counties, transportation is provided, but in other areas, transportation was insufficient. Regular transportation is expensive to provide and difficult to coordinate, but without it, patients may wait for crisis care. Many crisis visits can be eliminated by regular visits for routine examinations and immunizations.

The extent to which referrals occur often depends on the amount of cooperation between agencies serving migrants. In some cases, outreach workers provide migrant families with all the relevant service information regardless of which agency or organization sponsors the outreach.

Problems With Health Care Delivery

In eight of the twelve survey states, lack of funds was mentioned as a serious problem in the provision of health care to migrants. A related problem, reported in three states, was a lack of physicians. There are some nurses, but clinics and hospitals report that they are able to find few bilingual persons who have received education and training as nurses and other health professionals.

Hospitalization, continuity, and community resistance were each reported to be major problems by projects in five states. Hospitalization problems usually result from a dispute over which organization or agency will pay the bills. Although all medically indigent people must be served by hospital facilities constructed with Hill-Burton funds, hospitalization, and especially emergency treatment, is still a problem for migrants. In some cases, farmworker organizations pay a portion of the bills, and migrants continue to pay what they can, often over a period of years. Continuity of care for migrants in-stream is still a serious problem. Health project personnel in six of the twelve states reportedly utilize the National Migrant Referral Project, Inc. Although the health forms of the Migrant Student Record Transfer System convey information for school-aged and some preschool children, infants and preschoolers not enrolled in the Title I Migrant Education programs are usually not included on the MSRTS. A national health referral system must be established for migrant children to receive follow-up treatment for acute illnesses and chronic conditions. The existing systems are inadequate and would require additional funding to expand services to states now unserved.

Community resistance was cited by health providers as having a major negative impact on the delivery of health services to migrants. In some target counties, the attitudes of local residents and even some service providers were extremely hostile toward the migrant health project personnel. These attitudes unfortunately amplify migrants' problems in receiving needed services.

Other problems cited less often were third-party payor and funding application paperwork. It was suggested that grants for health care should be awarded for more than one year periods. This might enable project administrators to devote more time to securing state and local funding. Other health care providers regretted the lack of health research data available on migrants for use in comparison with nonmigrant populations.

Depiste the efforts of the very dedicated people serving in migrant health care projects, health care for the migrant child is still far from guaranteed. Preventive and well child care is often delayed indefinitely. Adequate care for sick children is dependent on many factors, which most Americans take for granted: a telephone to use in scheduling appointments or for emergency help, time off from work for doctor visits, transportation, convenient clinic hours, reasonable waiting room periods, easy communication with medical staff, and empathetic medical personnel. Unless a child is enrolled in a day care or school program which provides routine examinations and treatment, a child's health care is precarious, in most cases dependent on parents' efficacy to understand their children's needs in relation to a complicated, foreign health system.

Migrants generally reported that the quality of health care received was good. However, one woman queried who responded "good" later mentioned in passing that her husband had bled to death en route to a second hospital after being refused admittance to another, nearer hospital facility. Another woman's son died of internal bleeding following a misdiagnosis of injuries sustained in a fall. These cases of poor medical care or refusal of service still happen. These are the tragic cases that make headlines. Hidden from sight are the countless cases of children who receive no preventive care. A great toll is taken in the physical and mental health of all the children who see a doctor only when an acute illness occurs. Funding for services such as outreach and transportation is an essential component of health care for migrant children.

Migrant parent respondents spoke highly of the health care services their children had received. In evaluating the care, 90% of the parents indicated the care was good. Seven percent reported that either the service or the staff was not helpful. During the past year, 54% of the parents had needed health care for their children and, of those, 92% received the care. Although migrant parents generally obtain health care for their children when it is needed, their rating of services as "good" may be due in part to low expectations. In some cases, clinics were dirty and totally devoid of any character or color. In one case, there was no heat in the clinic. Perhaps migrants consider the care "good" if they receive any attention from a health professional. Despite the fact that they rated present health care "good", when they were asked about new child welfare services, the single service migrant parents mentioned most often was "better health care."

Conclusion

In spite of all efforts, the need for health care among migrant children is not being met. While the move toward community-based rural health care can benefit migrants through increased funding and resources, the special program requirements that make health care accessible to migrants must be maintained and improved: outreach, transportation, bilingual personnel, extended clinic hours, health education, and health referral systems. Without these program components, care is sporadic.

The value of health education cannot be overemphasized. Ultimately, parents are responsible for the health maintenance of their children, but until parents understand the importance of well child care, including regular physical examinations and immunizations, the community will have to assume some of this responsibility. Health care and other service providers to migrants must work to support migrants' efforts to obtain health care.

The health and health care of migrant children and families are also directly affected by the environment in which they live. Many of their personal health problems are created or aggravated by housing and sanitation factors in the camps, work hazards in the fields, and susceptibility to illnesses through constant traveling and crowded living conditions. These circumstances and their effects on migrant health are described in the following section.

Environmental Health

The lifestyle and environment of migrant children consist of constant traveling and adaptation to new and different homes and schools. From birth, migrant children are transient individuals, like their farmworker parents. They have few possessions and inadequate food, clothing, and housing. This is due primarily to poor salaries, resulting in economic conditions which require migrant families to leave their homes and follow the stream of seasonal agricultural work each year. Work opportunities are limited in home base areas. In order to ensure continued employment, migrants must travel to locations where agricultural labor is needed. The families still earn barely enough to survive and frequently find themselves in debt to crew leaders and in virtual peonage to the migrant system. Thus, they are usually unable to provide many basic necessities for themselves, and must rely on supplemental food programs and other forms of assistance provided by social service agencies. Breaking out of this yearly migration cycle to settle out of the stream is very difficult financially since families must have earned enough money to support themselves while seeking year-round employment. Continued employment is difficult to find and community response is often unfavorable to migrants wishing to remain in migrant labor areas. In addition, there is a continuing need for seasonal labor throughout the country. Thus, most families migrate during most of their lives and rear children who begin to work in the fields at an early age.

Housing

Children's physical and mental health, social development, and general well-being are directly affected by this lifestyle and the conditions under which the migrant family must live. The most obvious environmental concerns are evident in the housing conditions of migrant farmworkers. The deplorable housing in migrant camps and other rural dwellings has been well documented (Porteous, S.M., Migrant Child Welfare, pp. 65-69). Housing is inadequate to accommodate large families, is unsanitary, and lacks the essentials for a decent living environment. Typically, housing units consist of one small room per family, regardless of family size, with no electricity or plumbing. Communal bathroom and cooking facilities are frequently found. Holes in the roofs, windows, and walls are not uncommon, and many units have only dirt floors. Often, there are not enough beds for family members to sleep comfortably, and floor space is inadequate to accommodate a sufficient number of beds. This unsanitary, crowded environment contributes to disease and health problems which are aggravated by, if not a direct result of, these deplorable conditions. The serious consequences of poor environmental conditions are magnified for the large number of migrant families left without any shelter, now common in many regions.

The relationship between housing conditions and health is obfuscated due to confounding variables such as nutritional deficiencies. The problem of determining the effect of migrant housing on the health of migrants is complicated further by their transiency. While conditions may vary somewhat in the type of housing occupied by migrant families during the year, the conditions present in the majority of migrant camps are known to contribute to the incidence and spread of diseases. A recent example of the relationship between health and environmental conditions affecting migrants was seen in the 1973 typhoid outbreak in a migrant camp in Dade County, Florida, resulting from an unprotected water supply in addition to a poorly designed and constructed well and sewage system. A total of 225 cases of typhoid infection were found, the largest outbreak in recent history. Clearly, many illnesses would be preventable if housing inspections were conducted and resulted in improvements, and if migrant children received the same basic care as other children.

Other environmentally related diseases prevalent in the migrant population include tuberculosis, internal parasites, diarrhea, other infectious diseases, and lead poisoning. Many camps use lead-based paint, and children have been known to eat paint chips--causing serious illness. Internal parasites are related to the lack of proper disposal of body waste and insufficient facilities for washing hands. Hookworm is transmitted through the bottom of the feet to the internal organs of the body. Since many family members do not have shoes, hookworm has been a serious problem for migrant children.

Infectious diseases are a particular threat to migrants because of crowded living conditions. Immunizations against diseases such as measles, mumps, diphtheria, tetanus, and pertussis are more routine among the general population than for many migrant children who do not receive the necessary immunizations. These diseases, as well as less serious infectious illnesses, are rapidly transmitted among family members who are in close contact and without adequate sanitation. Elimination of overcrowding and the prevalence of more sanitary bathroom facilities in closer proximity to the living units would help alleviate many of these illnesses.

The type and availability of migrant housing was found in this study to vary between states and within each state. Generally, four kinds of housing arrangements were found: private rental, employer furnished, family owned, and public rental. Additionally, when no housing is available, families who need work must live wherever they can. One migrant mother in Colorado told the interviewer during the family survey, "Sometimes you can't find a house, like this summer we had to stay in the car." This is typical of many situations in Colorado where housing is particularly scarce; almost none has been available for migrants. The situation has been improving somewhat in the past few years, however, due to the state's provision of matching grants to public and nonprofit organizations for new and rehabilitated housing. Many people feel that the rent in the state-supported units is still too high, even though they were built for low-income families.

In Washington state, many families were camped along the banks of the Yakima River. Having to camp out resulted when OSHA regulations were enacted. Rather than incurring the expense to bring the camps up to the standard required after inspections, growers closed their camps. The only housing currently available in this area is operated by the county health department. This "camp" actually consists of 19 parking spaces with central sanitary facilities. Providing outreach services to families scattered in isolated encampments is a particularly difficult problem. One local welfare office does provide outreach and referral to these families on a voluntary basis. Respondents indicated that screening for typhoid and shigella is provided in order to prevent the spread of these communicable diseases to local residents.

In-stream, the housing most commonly available to migrants is furnished by the employers. Employers who use state employment services are required to provide housing which is inspected and kept up to minimum standards. However, farmers who do not want to upgrade their camps to meet this requirement choose not to use the employment service. In these cases, it is serving neither employers nor workers. There is some employer-furnished dormitory housing for single men, especially in the East Coast region where many single males work. However, there are a large number of families also who occupy grower-owned housing.

The number of employer-furnished camps has substantially decreased with the advent of OSHA. It is too costly, according to the owners, to meet the minimum safety and health requirements. The result has been large scale closing of migrant camps nationwide. A few states rejected the OSHA program, and use state inspection regulations. One such state is New Jersey. Many state employees in New Jersey were eliminated leaving just a few employees to monitor camps statewide. Before the OSHA was rejected in 1974, 6,000 inspections of 1,000 labor camps in New Jersey found 18,000 violations. After the OSHA program was rejected in 1975, only 200 federal and 300 state inspections were conducted. The State of New Jersey has affirmed that due to this inadequate inspection and supervision, the risks to children living in these camps are severe. Most camps are inspected and licensed by the health departments. Many of the small farms employing workers for less than 500 worker days for OSHA regulations, and under ten workers (by many state laws), are exempt from inspection. A very large number of farms, over one-half of those in New Jersey, are in this category. Thus, many families are not protected by any laws governing camp conditions.

One migrant woman in Colorado reported of grower-owned housing: "The housing around here is terrible, there's no water, restrooms, or privacy. The building is badly in need of repair. It gets very cold here and everyone gets sick. If they would fix these places up, our health would be much better."

Not all grower-owned housing is substandard, but the vast majority is either substandard or barely meets the very minimum standards required. In Illinois, families were found to be living in converted storage sheds in one camp. Some new housing has been built in Illinois; however, even the new housing has communal restroom facilities, and the wiring is not in conduit. A migrant mother of seven children told the interviewer that unless the farmers provide housing, it is "very hard to find a place" when they have so many children. Another woman said, "The houses are very cold and the children always get sick." But with no shelter or sanitary facilities, conditions might be worse. The need exists to ensure that employers, rather than providing no housing or closing what does exist, bring their camps up to the standards for the health and safety of the occupants.

Access for migrants to necessary health services is severely limited by the isolation of migrant housing in grower-owned camps. Workers often must rely on crewleaders or employers to furnish transportation for needed services. Thus, employers and crewleaders have some control over when families leave the camps. Access to the camp from outsiders, such as social workers and legal aid personnel, is also frequently controlled by the camp owners. While several lawsuits have been filed against employers for restricting access to camps, access is still limited illegally in a number of states. While the practice is most notably an affront to human dignity, it also affects migrants' utilization of health care and other family social services. Contributing to a migrant family's lack of economic independence is the rent which is often charged migrant families for occupying housing which is so frequently substandard.

Private rental is another common housing arrangement for migrant families. This is found more frequently in the home base areas of Florida, Texas, and California. There are often clusters of migrant housing on the outskirts of rural towns in home base areas. Typically, these are squalid settlements of either private rental or family-owned homes. One example of this is in Immokalee, Florida, where the housing consists of wooden hovels and tarpaper shacks. Often these settlements have great difficulty obtaining the use of public utilities. A farmworker group in Palm Beach County received federal money for the construction of housing. The city council attempted to prevent construction of the housing and then refused to connect necessary public utilities. A federal court later ruled this to be discriminatory. Unfortunately, by that time, funding was no longer available to construct the housing.

Another graphic example of these difficulties in obtaining decent living conditions occurred in Texas. There has long been a struggle to bring safe drinking water to the two hundred or more residents of two "colonias," rural farmworker settlements, in Weslaco. In 1973, the town of Weslaco received a federal grant to construct water lines into the two colonias, bringing them city water for the first time. However, this was never accomplished and the grant money was spent on other city projects. The farmworkers' organization and the rural legal aid office continued to bring this oversight to the attention of city officials, which resulted in a new grant in the fall of 1976 (DeWeaver, N.C., "Valley Residents Struggle For Safe Drinking Water," Austin, Texas: The Texas Observer, December 1976 as cited in Federal Programs Monitor, Washington, D.C., December 1976, pp. 1, 6, 8.).

Other colonias in the area have had similar problems. In the colonias of Balboa, Texas, families hauled drinking water from sources of "uncertain quality," and many drank water from irrigation ditches. Ironically, the town was situated next to a lush, well-watered golf course. The colonias' residents finally succeeded in getting the water lines built; however, they were not permitted to hook up to the lines until their homes met the city code requirements which included indoor plumbing. An additional $100,000 had to be raised to help families meet these new requirements.

The usual dilapidated, spatially inadequate private rental housing, with few if any personal comforts or sanitation, is often occupied at very high monetary cost to the family. A substantial portion of their meager income goes toward providing substandard shelter and the only other alternative for migrant families, though not widely available, is public rental housing. This type of housing is federally-, and sometimes state-assisted and is operated by either the Farmer's Home Administration (FmHA) of the U.S. Department of Agriculture, the Department of Housing and Urban Development (HUD), or the Department of Labor (DOL). FmHA can provide assistance with a grant or a loan. However, these federally-assisted projects, both public and private, are of limited help to migrants since rent or regular mortgage payments must still be paid and are frequently more than a family can afford. Also, migrants are away from home several months of the year, making it even more difficult to make monthly payments for a permanent home.

In the state of California, some of this federal housing money has assisted the state in construction of twenty-six state migrant labor camps specifically for farmworkers. The camps are open for six months of the year and are affordable at $1.50 per day. Day care centers are also located in the camps, eliminating transportation problems. However, long waiting lists and lines for the opening of these camps are testimony to the scarcity of these housing arrangements and its impact on a very small number of farmworkers.

Another "model" federally assisted project, Farmworker's Village in Collier County, Florida, has been very successful, but aids only a relatively small number of farmworkers. This project was assisted through FmHA and includes 150 units near Immokalee, Florida. Built in 1973 by the Collier County Housing Authority with a $1,600,000 grant and an $800,000 loan from FmHA, the buildings are one-story single family homes in generally good repair and with sanitation facilities. Due to the project's success, a new grant for $3,276,600 was awarded to expand the facility by 120 units.

FmHA also sponsors a Self-Help Housing project in Florida. While migrant families have taken advantage of the opportunity to build and own a house, it takes long and hard work for perhaps four to six months. This means the family must stay in the area during this time, and it also requires an initial financial investment many migrant families cannot afford. Continued monthly payments are also required. Thus, a fairly small number of migrants have been affected.

It is interesting to note the results of the family survey which show that when asked what problems they face raising children in-stream and while home based, the largest single problem mentioned was housing. In-stream, 20.6% of the respondents listed housing problems; 15.8%, caring for children during the day; and 11.1%, school problems. At home base, 25.2% listed housing; 11.9%, school problems; and 8.0%, caring for children during the day. Also, families in the East and West Coast streams listed housing problems more frequently than families in the mid-continent stream. Additionally, those families settling-out of the stream reported more frequent housing problems than those families currently doing migrant agricultural work (31.2% compared to 19.2%, respectively). When asked what new child welfare service they wanted--even though housing is not usually considered a child welfare service--13.0% of the settled-outs and 9.3% of the currently migrating families said housing aid was needed to better their children's welfare.

One migrant mother summed up the situation and their needs by stating, "(We need) a service where you get a house and it's ready and it has water, bathrooms, floors, electricity--a place where we could relax when we get done working instead of just more work--like going after water."

Services to migrant families in the area of environmental health are extremely limited. Health facilities, such as migrant health clinics and county and state health departments may assist in the licensing of camp housing in some states, but they typically have no further influence on environmental conditions. Even assisting in licensing has limited impact since in many states few inspections were conducted and frequently no follow-up inspection ensured compliance by the camp owners. Also, if a temporary license for camp operation is issued, this often lasts until the migrants have left the region.

Other environmental health services which may be provided were only found in isolated cases. In California, one county health department requests information in their registration forms concerning whether children have beds of their own and whether refrigeration is available. The staff then checks the responses, and a public health nurse counsels parents in ways of providing safe, separate beds for infants and children, food preservation, and poisoning dangers. This type of program is an excellent environmental health service. In Iowa, the migrant health project director and a nurse from the project attended a five-day seminar on environmental sanitation. Information gathered from such a seminar increases staff awareness of the migrant's environment and the extent of resulting health problems. Clinic staff members should be aware that migrant children have already been exposed to an environment which is seriously detrimental to their health before they are even seen at the clinic making it difficult to practice real preventive medicine. Unfortunately, funding and staff constraints as well as the unwillingness of the clinic or agency personnel, prevent the offering of environmental services, such as sanitation education, poison prevention, and assistance in the construction of temporary beds for young children.

The migrant family is extremely limited in the housing alternatives available to them. This is a by-product of their lifestyle which yields insufficient incomes, forces them to find temporary shelters, and subjects them to exploitation by employers and landlords. It will be necessary in the future to ensure that housing is inspected and brought up to standards required by state and federal law. Federal and state governments should investigate more possibilities for decent, temporary housing arrangements for migrant workers. It is also necessary to expand existing "model" facilities that have already proved successful, such as the state migrant labor camps in California and Farmworker's Village in Florida, to effect greater impact on the migrant housing situation.

Children in the Fields

Migrant families not only encounter adverse environmental conditions at home and in the camps, but also at work in the fields. Preschoolers spend much time just sleeping or playing at the edge of the field until they are old enough to "pick." Many children begin to do some work in the fields by age four, and by age ten they are expected to carry their own weight, usually leaving school to work full time by age twelve.

The problem of child labor has been eliminated in all occupations except agriculture. Historically, farmworkers have been exempt from much of the federal protection given in other occupations. Even though agriculture has the third highest occupational fatality rate, child labor provisions are not so stringent for agricultural as for non-agricultural sectors.

Child labor is often an economic necessity for the migrant family. Indeed, many people agree that family welfare is better served if every able member works to enhance earnings. While child labor contributes minimally to the growers production, every extra dollar earned by the children is essential to the family's needs. Migrant children feel a responsibility to their family to help with income. Unless there is a program such as "Learn and Earn" or work/study program which provides an economic incentive to stay in school, children are forced to drop out by the time they reach high school.

In the states surveyed, it was reported by the farmworker organizations that a large number of children under age 12 are working illegally. It was reported in three states that between 50% and 60% of migrant children of all ages work illegally, and in four other states over 80% of the children worked illegally. This is a tremendous number of children who are spending long, hard days bending or stooping to harvest crops. Many of these children attend school part of the day and work in the fields before and after school hours. A much larger number of children work during the summer and during the break between summer and fall school programs.

The federal child labor laws allow children aged 14 and over to work in agriculture. In many cases, children aged 12 can work with parental consent. The enforcement of these minimal laws can be difficult. Law enforcement officials must visit the fields and observe children working. This is rarely done and many children have learned to stop working when strangers are in the work areas. Also, it was reported that school truant officers rarely "bother" to ensure the attendance of migrant children. As a result, the education, health, and development of working migrant children is impaired.

Many children who are too young to work, generally under age four, may still spend their days in or near the fields where their parents are working. These infants and toddlers are frequently cared for by older siblings. This arrangement provides only minimal care for the children and prevents the older siblings from attending school. At other times, young children are left completely unattended, sleeping in cars or in baskets by the edge of the fields. Recently, in Florida, a young child suffocated while left in a hot car near the working parents. No law prohibits presence of young children in the work areas. As a result, many preschoolers, especially infants, are exposed to hazardous conditions. These hazards are numerous and, in many cases, have had serious consequences.

Exposure to pesticides which are used in the fields has been a major problem to all family members. Migrant health clinic respondents in the states surveyed reported that skin infections and upper respiratory problems were common in the migrant population. Clinic staff indicated that these conditions were related to pesticide exposure. However, funding and time constraints prevented the staff from determining the extent of pesticide abuse. Therefore, the actual incidence of ill effects from pesticides in the fields is difficult to determine. In Iowa, the migrant health clinic recently received funds to follow up on suspected pesticide cases to determine if there has been misuse and where this has occurred. Since the migrants move so frequently, it is often impossible to determine the source of pesticides exposure and to ensure adequate treatment for the victims.

One of the most publicized and serious cases of pesticide poisoning was reported in the state of New Jersey. A ten-year-old boy who had accompanied his family to the field fell asleep in the car. While he was sleeping, a plane sprayed the field with pesticides. The child's lungs were burned, and, after two weeks in a coma, he died. The seriousness of this incident, and similar incidents which have resulted in the death of migrant children, is testimony to the dangers of children being allowed near the fields. Another incident was reported in California. A truck in which pesticides were spilled later carried work clothes. People who purchased the clothes developed rashes and other symptoms of pesticide poisoning. Many young children are indirectly exposed to pesticides in a similar manner. Pesticide residue is brought home on the clothes of family members who are then in contact with their children. Bilingual pesticide-safety information is available from several of the farmworker organizations and health clinics. The distribution of this information is extremely valuable to the safety of migrant farmworker families.

Farm machinery has also been found to be a hazard to the well-being of migrant children. Several cases have been reported in which young children received accidental injuries operating large tractors. The state legislature of New Jersey is currently considering a bill to allow 12-year-old children to work in processing plants associated with farms. The work includes the use of power tools which would be a great danger to child safety.

Migrant parents do not feel that they have the economic choice of whether to allow their older children to work. Day care is the most viable alternative for migrant parents who do not want to bring their younger children with them to work. The need for day care was asserted by respondents from a variety of service organizations in the states surveyed. In addition, respondents' proposals to alleviate the child labor problem included the following guidelines:

- Day care, when provided, should offer transportation and be concurrent with the work hours of the parents;
- Infant day care should be provided; it is a particular concern since a large percentage of the children in the fields are infants;
- Extended day care (before and after school care) for school-aged children is essential to provide an

alternative to those children working, or being left unattended, after school hours;

- Individual worker's earning power should be greater; this would allow someone to remain in the camp to care for the children, without reducing family incomes;
- Outreach and recruitment activities should be increased by the schools in order to enroll all eligible children in school programs;
- Learn and Earn and similar work/study programs should be encouraged in order to offer an economic incentive to secondary-level students for remaining in school;
- School curriculum should be appropriate and relevant to the migrants' experiences and needs, and emphasize vocational training for older children.

Unfortunately, none of the services and needs listed above are assured to migrants while in-stream or while home based. Where the services do exist, they are typically inadequate to serve all families needing them. The results of this inadequacy, coupled with the dire financial needs of the family, are seen in the large percentages of children either laboring in the fields, or suffering from the ill effects of environmental hazards, such as pesticides and farm machinery, in the work areas.

These problems of housing, child labor, pesticides, and constant traveling are inherent in the migrant lifestyle. Migrant adults as well as their children are affected both emotionally and physically. It is clear that the overall environment and transient lifestyle of the migrant family is far from optimal for child development. Legislative protection is sparse and poorly applied, and provision of services is inadequate considering the severely detrimental factors making up the child's environment. Migrant children living in this environment suffer from what may be called a "situational" neglect that is a condition of the migrant livelihood. The migrant family's low socio-economic status has not allowed them to provide sufficient care for their children in health, nutrition, clothing, shelter, or psychological support. This type of neglect, while not deliberate, may nonetheless have serious effects on migrant child welfare.

PART THREE

HOUSEHOLD SURVEY: FAMILY INTERVIEWS

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FAMILY INTERVIEWS

The delivery of child welfare services to migrants in the areas of social services, child care, education, and health was discussed in the preceding section, "Services to Migrant Children." This section of the report will examine the actual receipt of those services by migrant children and their families. The data presented here were collected in eleven states by interviewing migrants to determine the extent to which they utilized available services, and their response to the services provided. The purpose of conducting family interviews was to give an added perspective to the previous analysis by examining the extent to which needed services were actually obtained, as well as to present an evaluation of those services by the recipients. The family interviews were conducted in the same states as those where social service agencies were studied. The family interviews, however, do not constitute a test of service delivery by these same agencies because migrants were not necessarily living in the state in which they were interviewed at the time the services were needed or utilized. For instance, a family may have been interviewed about services in New Jersey, but the services on which the family reported may have been received elsewhere earlier in the season while the family was working in a different state. Nevertheless, these interviews provide valuable insight into the delivery and receipt of services within the migrant community.

The interviews were conducted in September 1976, with 750 migrant farmworker families residing in 11 states. With few exceptions, the family interviews were held in the same counties and states as the agency interviews (See Appendix A). An exception was in Colorado, where interviews were held in both Weld County and the San Luis Valley. It was necessary to interview in the San Luis Valley because, at the time the interviews began, most migrants had already left Weld County due to an unusually cold autumn. Another exception was Maryland, the pretest state. The pretest form of the questionnaire differed significantly from the final form used in the other states. As a result, the Maryland interviews did not provide information that was sufficiently comparable to that obtained in the other states where family interviews were conducted.

Interviewers were of the same ethnic and racial background as the majority of migrants in their state. In all cases, the interviewers were women, and the interviewers were instructed to speak with the mother of the household, if at all possible. This procedure was used to facilitate a discussion of problems in raising children. The total time for each interview was twenty minutes. However, the interviewers were instructed to allow the mothers to talk longer if the mothers desired to do so, and many women talked at length about problems they had in raising their children. In addition, conversation before the interview, necessary to establish rapport and to gain the mother's confidence, sometimes extended the total time beyond twenty minutes. Interviewers were instructed to

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obtain a total of eighty interviews in each state. The interviews were not random because the size and location of the total migrant population cannot be determined easily. Instead, the interviewers used their own knowledge of the area to find migrants who were available locally at the time of the interviews. Because the sample is not random, generalizations derived for the migrant population as a whole cannot be justified statistically.

A breakdown of the number of interviews conducted in each state is shown in Table 1. As can be seen in the table, with the exception of Washington (N=20), the state goal of 80 interviews was approached in most of the states.

TABLE 1. State in which Interview Was Held
(N=742)

State	Number
California	57
Colorado	73
Florida	80
Illinois	79
Iowa	68
Michigan	66
New Jersey	60
New York	80
North Carolina	79
Texas	80
Washington	20
(Missing Data)	8

For the most part, the person interviewed was the mother, as shown in Table 2.

TABLE 2. Person Interviewed
(N=720)

Respondent	Number	Percent
Father	48	6.7%
Mother	538	74.7
Both Parents	134	18.6

The purpose of the interviews was to determine demographic characteristics of the migrants, the services needed and the services actually obtained, and the major problems migrant mothers perceive in raising children at home base and in-stream. In general, it was found that most migrant mothers were relatively young and had rather large families, and migrant families tend to remain intact, even while migrating. In time of trouble, the mother would generally prefer to go to members of the family or to a farmworker organization for help. The crew leader, camp owner, and priest or church-related person were all individuals from whom the migrant would be least likely to seek help in times of need.

Most mothers whose children needed health care reported that the necessary care was obtained and that it was satisfactory. Day care was not obtained so frequently, and children were often cared for by older siblings or left unattended. Agency Family Services were very seldom utilized; most of the migrants relied on friends or relatives to help them when the mother was sick. Supplemental educational services at school were made available to some of the children, but many parents did not know which services, if any, their children were receiving. Very few mothers reported that their children received bilingual education.

Finally, when questioned as to their major problems raising children, housing was the problem mentioned most frequently. The quality of education was also a problem, as was gaining access to day care while in-stream. Better health care, better education, and more day care facilities were all services the migrant mothers reported that they would like to have.

In interpreting the data from the family interviews, an important caution is necessary. These data may present an overly favorable picture of social services delivery to migrants. There are two reasons for this. First, the sample may have been biased toward those migrants who received services. In order to locate the required number of respondents, the interviewers frequently went to areas where migrants were known to be, and this sometimes included areas near migrant health clinics or day care facilities. The sample was thus not random in its selection of migrants, though a random sample would have been nearly impossible to obtain due to the inaccessibility of migrant population. Second, some of the interviewers reported a reluctance on the part of the migrants to discuss or even admit problems in response to the questions. The conditions witnessed by the interviewers, or problems discussed spontaneously following the interview, sometime stood in stark contrast to the responses to the questions during the interview. For instance, when asked about health care, one respondent reported that service was fine, but the interviewer recorded the following conversation:

> "While I was working [here], they told me I was too many months pregnant to see [at the local clinic]. They referred me to [a clinic in another town]. [That clinic] said I was in the wrong county. I had to go to a clinic in [a different city] and must wait until September 13 for an appointment. I am worried because the baby is due September 20 and it will have to be Cesarean."

During another interview, the respondent had no complaints about the health care received, and said she would go again if the need arose, but the interviewer made this note on the questionnaire:

> Could not complete interview because the woman became hysterical. She just returned from Texas. Her son died there recently from a fall. She said a misdiagnosis took his life. Her son was walking around with internal bleeding for three days before the doctor determined the problem.

In another case, the respondent reported that she had no problems at all raising children, but the interviewer noted after the interview was completed:

> The house was appalling. It only had three walls. There was no heat, no electricity, and no running water. It was below freezing inside. The house had a dirt floor. Cooking was done on an open fire in the middle of the room. The house appeared typical of houses in the area.

The living conditions of migrants, the access of migrants to services, and the quality of those services as reported in these interviews may, therefore, appear to be better than is actually the case.

A detailed presentation and analysis of the responses to each question follows.

Demographic Characteristics of the Sample

Chicanos comprise the largest single ethnic group of migrants in the sample; 68.2% of the persons interviewed are Chicano. The next largest group, with 20.2% of the persons interviewed, is made up of Blacks. Other ethnic groups comprise only a small portion of the total sample. These results are presented in Table 3.

TABLE 3. Ethnic Background of Respondent (N=725)

Ethnic Background	Number	Percent
Chicano	495	68.2%
Black	146	20.2
Puerto Rican	41	5.7
Native American	20	2.8
Anglo	10	1.4
Filipino	6	0.8
Other Spanish-speaking	6	0.8
Asian, Oriental	1	0.1

Overall, migrants appear to be young. As shown in Table 4, the mean age of the persons interviewed is 31.4 years.

TABLE 4. Age of Mother
(N=722)

Age*	Number	Percent
Under 20	35	4.9%
20-24	135	18.7
25-29	155	21.4
30-34	122	16.9
35-39	98	13.6
40-44	80	11.1
45-49	50	6.9
50-54	36	5.0
55 and older	11	1.5

*Mean age, based on ungrouped data, is 31.4 years.

Table 5 shows that the mean number of children living at home with the parents was 3.43. Only about 15% of the families interviewed had six or more children, and about the same proportion of families had only one child. This information is presented in Table 5.

TABLE 5. Number of Children under 18 Living with Respondents
(N=731)

Number of Children*	Number	Percent
One	108	14.8%
Two	150	20.5
Three	163	22.4
Four	106	14.5
Five	89	12.2
Six	47	6.4
Seven	33	4.5
Eight	20	2.7
Nine or more	15	2.0

*The mean number of children is 3.43.

The mean number of children is larger for this sample of migrants than for the national population as a whole. Even so, the average family size, including two parents, is less than six. Table 6 shows that the vast majority of respondents, 96.5%, indicated that all the children living with them were theirs.

TABLE 6. Relationship between Mother and Children Living at Home (N=711)

Relationship	Number	Percent
Own children	686	96.5%
Not own children	25	3.5

Over 90% of the people interviewed reported that they had no children under 18 who were not living with them. The number of migrant children living at home are shown in Table 7.

TABLE 7. Number of Children Not Living at Home (N=750)

Number of Children	Number	Percent
None	679	90.5%
One	46	6.1
Two	23	3.1
Three or more	2	0.3

Using these demographic data, a "typical" migrant family can be described. The typical family in this study was Chicano or Black. The migrant mother was young, usually in her early 20's. The family had three or four children under the age of 18. Normally, parents and children migrated together as a family unit.

Migration Patterns

The two largest home base states in our sample were Texas and Florida. Slightly more than 75% of the migrants interviewed are based in these two states. No other state had more than 6% of the sample living there in winter. The numbers and percentages of migrants living in various home base states are presented in Table 8.

TABLE 8. Home Base State
(N=574)

State	Number	Percent
California	33	5.7%
Colorado	12	2.1
Florida	189	32.9
Illinois	10	1.7
Iowa	8	1.4
Michigan	5	0.9
New Jersey	19	3.3
New York	4	0.7
North Carolina	1	0.2
Texas	246	42.9
Washington	11	1.9
Other	36	6.3

Additional data obtained on migration patterns concerned the frequency of migration. The respondents were asked the longest period of time (in years) during which they did not migrate. The largest percentage reported "none," indicating that they migrate at least once a year, as seen in Table 9.

TABLE 9. Number of Years with No Migration
(N=626)

Number of years	Number	Percent
None	274	43.9%
One	158	25.2
Two	76	12.1
Three	41	6.5
Four	19	3.0
Five or more	58	9.3

The respondents were asked the number of migrations they have made in the past five years. A majority reported that they had migrated five times in the past five years, indicating, again, a pattern of one migration a year. The number of migrations made in the past five years is shown in Table 10.

TABLE 10. Number of Migrations in Past Five Years
(N=681)

Number of Migrations	Number	Percent
One	38	5.6%
Two	66	9.7
Three	96	14.1
Four	75	11.0
Five	360	52.8
Six or more	46	6.8

A majority of the sample, therefore, appears to have repeated the pattern of one migration per year, each year. The overwhelming majority had not even spent so long as three years without making a migration. For most of the respondents, the current migration represented the fifth trip in as many years.

Attitudes toward Sources of Help

An attempt was made to determine the respondents' attitudes toward seeking help from a number of different sources. Respondents were asked their attitudes toward the following commonly noted sources of help: members of the extended family, friends or neighbors, crewleader or his wife, farmworker organization, priest or church-related individual, camp owner or employer, a local service organization, and a state welfare agency. Respondents were asked about each of these sources in turn. For each source, the interviewer used the same question, "How would you feel about going to ______ for help?" The interviewers were instructed to copy down the answers verbatim. They were also instructed not to probe extensively, for fear of extending the interview past the twenty-minute time limit. Thus, for each question a large proportion of the responses were very general positive or negative answers, such as "They're fine," or, "No, I wouldn't [illegible] there." Codes were developed from the more definite responses. The responses of "Maybe I'd go there," as well as limited positive responses were coded as "It depends" to indicate that the source would be used only under specific conditions. Other responses indicated that the particular source is not available, the source is not helpful, or was not helpful in the past, or that the respondent would be hesitant to use that source. Responses such as, "I have no confidence in that source, or, "I don't trust them," and remarks indicating fear were coded as mistrustful.

The attitudes toward these helping sources are presented in Tables 11 through 18. Table 11 presents the responses for attitudes toward going to members of the extended family for help. As seen in Table 11, just over half of the respondents expressed positive attitudes toward seeking help from members of the extended family. The most common reason for negative responses was that members of the extended family were not available (probably due to the fact that the extended family had not migrated with the respondents), and hesitancy.

TABLE 11. Attitude toward Members of Extended Family as Helping Source (N=685)

Attitude	Number	Percent
General positive comment	352	51.4%
General negative comment	183	26.7
"It depends"	31	4.5
Source not available	53	7.7
Source not helpful	11	1.6
Hesitant to use source	52	7.6
Mistrustful of source	3	0.5

The data for friends and neighbors are presented in Table 12. Here, the positive responses were much fewer; only about a third, 34.3%, had positive attitudes toward going to friends or neighbors for help. Most of the negative replies could not be coded, but 8.2% of the respondents stated clearly that they were hesitant about going to friends or neighbors.

TABLE 12. Attitude toward Friends or Neighbors as a Source of Help (N=679)

Attitude	Number	Percent
General positive comment	233	34.3%
General negative comment	319	47.1
"It depends"	27	4.0
Source not available	35	5.2
Source not helpful	2	0.2
Hesitant to use source	56	8.2
Mistrustful of source	7	1.0

Attitudes toward the farmworker organization as a source of help are presented in Table 13. Along with members of the extended family, the farmworker organization received the largest percentage of positive responses. Apparently, the farmworker organization is useful to the farmworkers, and appears to them to be a valuable source of help. Although more than one-third of the responses were generally negative, no specific negative responses were mentioned often enough to prove meaningful.

TABLE 13. Attitude toward Farmworker Organization as a Source of Help (N=618)

Attitude	Number	Percent
General positive comment	320	51.8%
General negative comment	221	35.8
"It depends"	37	6.0
Source not available	22	3.6
Source not helpful	5	0.7
Hesitant to use source	11	1.8
Mistrustful of source	2	0.3

Table 14 presents the responses for attitudes toward the state welfare agency. The state welfare agency received mixed ratings; almost half, 45.9%, were general positive responses, and almost 40% were general negative comments.

TABLE 14. Attitude toward State Welfare Agency as a Source of Help (N=662)

Attitude	Number	Percent
General postive comment	303	45.9%
General negative comment	259	39.1
"It depends"	48	7.3
Source not available	6	0.9
Source not helpful	15	2.2
Hesitant to use source	29	4.3
Mistrustful of source	2	0.3

On the other hand, local, private service-oriented organizations received only about a third, 34.1%, positive responses, and almost half, 47.2%, negative responses. In addition, a sizeable proportion, 8.5%, of respondents reported that they would use local organizations sometimes, while 5.6% of respondents indicated that there was no local organization. These data are presented in Table 15.

TABLE 15. Attitude toward a Local Organization as a Source of Help (N=621)

Attitude	Number	Percent
General postive comment	212	34.1%
General negative comment	292	47.2
"It depends"	53	8.5
Source not available	35	5.6
Source not helpful	11	1.7
Hesitant to use source	17	2.7
Mistrustful of source	1	0.2

Migrants, then, do not generally view local organizations as useful, while state welfare agencies are seen as being considerably more useful.

Table 16 presents the responses about seeking help from the crewleader or his wife. Over half of the respondents held negative attitudes toward the crewleader or his wife as a source of help.

TABLE 16. Attitude toward Crewleader or His Wife as a Source of Help (N=639)

Attitude	Number	Percent
General positive comment	165	25.8%
General negative comment	388	60.7
"It depends"	22	3.4
Source not available	33	5.2
Source not helpful	0	0.0
Hesitant to use source	28	4.4
Mistrustful	3	0.5

In Table 17, it is shown that about one-fourth of the respondents held a generally positive attitude toward the camp owner or employer as a source of help.

TABLE 17. Attitude toward Camp Owner or Employer as a Source of Help (N=616)

Attitude	Number	Percent
General positive comment	156	25.3%
General negative comment	397	64.5
"It depends"	23	3.7
Source not available	17	2.8
Source not helpful	4	0.6
Hesitant to use source	16	2.6
Mistrustful of source	3	0.5

The attitude toward the local priest as a helping source is presented in Table 18.

TABLE 18. Attitude toward Priest or Church-related Individual as a Source of Help

(N=636)

Attitude	Number	Percent
General positive comment	182	28.6%
General negative comment	394	61.9
"It depends"	36	5.7
Source not available	0	0.0
Source not helpful	4	0.6
Hesitant to use source	17	2.7
Mistrustful of source	3	0.5

The three sources received only about one-quarter positive responses. Thus, the farmworkers sampled generally felt that the crewleader and his wife, the camp owner or employer, and the priest or church-related individual were of limited utility as sources of help and/or these individuals were not well accepted by the farmworkers.

Overall, the sources of help that received the highest number of positive comments and the most strongly favorable responses were relatives and the farmworker organizations. The mothers sampled had considerably more positive attitudes toward relatives than toward friends. It is thus not wholly correct to say that farmworkers would turn to friends and relatives in time of need. Attitudes toward agencies including the state welfare agency and local organizations were, in general, more often negative. Local organizations, i.e., private sector service-oriented associations, were very poorly regarded as sources of help. Few respondents expressed positive feelings about turning to sources other than relatives or the farmworker organization. The crewleader, the camp owner, a priest or other church-affiliated persons were, for the most part, viewed negatively as sources of help.

Utilization and Evaluation of Child Welfare Services

The family interview questionnaire focused heavily on child welfare services the respondent may have needed and utilized. Respondents were questioned about health care, day care, family services, and supplemental educational services such as bilingual education and individualized or small group instruction. For each of these areas, the questions were directed at determining the following: a) whether the service was needed during the previous year; b) whether the service was provided or obtained; c) if the service was not provided or obtained, then why that was the case; and d) how the respondent evaluated the service. In addition, several questions were asked concerning the receipt of a few additional services that did not fit into the above-mentioned categories. These services included free breakfast and free lunch at school, help with family planning, and the receipt of free clothing for children. The responses for each of the areas will be discussed separately below.

Health Care

Table 19 shows that just over half, 54.1%, of the respondents reported that they needed health care for at least one of their children within the past year.

TABLE 19. Need for Health Care within the Past Year
(N=723)

Need for Health Care	Number	Percent
Health care needed	392	54.1%
Health care not needed	331	45.9

Of those who needed health care, almost all, 92.3%, received some form of health care. The data on health care received are presented in Table 20. Since very few respondents had failed to receive health care, no analysis was made of the reasons for which health care was not obtained.

TABLE 20. Health Care Received within the Past Year
(N=391)

Health Care Service	Number	Percent
Health care received	361	92.3%
Health care not received	30	7.7

The evaluation of the health care received was overwhelmingly favorable; less than 10% of the respondents made negative comments concerning the care they received. The evaluation of health care received is shown in Table 21.

TABLE 21. Evaluation of Health Care Received
(N=356)

Evaluation	Number	Percent
Service was good	324	90.9%
Service not helpful	16	4.6
Did not like their attitude	10	2.8
Service too expensive	3	0.8
Transportation problem	2	0.6
Not applicable/ineligible	1	0.3

Finally, the respondents were asked whether they were living at home base or in-stream when they received health care. As seen in Table 22, a majority, 59.4%, reported that they were living in-stream at the time.

TABLE 22. Place of Residence When Health Care Was Received (N=357)

Place of Residence	Number	Percent
Home base	145	40.6%
In-stream	212	59.4

In general, then, health care was almost always obtained when it was needed, and the evaluations of the care received were very favorable. (For cautionary interpretation of these data, please see pp. 135-136.)

Day Care

Of the mothers surveyed, 61.7% were employed. The employment status of migrant mothers is presented in Table 23.

TABLE 23. Employment Status of Mother (N=729)

Employment Status	Number	Percent
Employed	450	61.7%
Not employed	279	38.3

A breakdown of who cares for the children while the mother works is shown in Table 24. Almost half, 48.0%, of the children of working mothers were cared for at some sort of day care center. Almost one-third, 30.7%, of the children were left unsupervised by adults. This includes children left in the care of an older sibling.

TABLE 24. Arrangements for Child Care while Mother Works
(N=811*)

Child Care Arrangements	Number	Percent
Friends	51	6.3%
Relatives	49	10.2
Agency	389	48.0
No One	249	30.7
Miscellaneous	29	4.8

*N equals more than total number of respondents because some respondents answered for more than one child.

Table 25 shows that about half, 51.4%, of the respondents reported that they needed day care for their children. The remainder apparently felt that their children were old enough to be able to take care of themselves, or that the present arrangements were satisfactory.

TABLE 25. Need for Child Care within the Past Year
(N=655)

Need	Number	Percent
Child care needed	337	51.4%
Child care not needed	318	48.6

Of those who felt day care was needed, the need was greater in-stream, 54.7%, than at home base, 45.3%. The area in which day care is needed is reported in Table 26.

TABLE 26. Where Child Care Services Are Needed
(N=254)

Where Services Needed	Number	Percent
Home base	115	45.3%
In-stream	139	54.7

An evaluation of day care is shown in Table 27. Less than two-thirds of the respondents made positive comments. The negative comments tended to vary; the only problem that seemed to be repeated often was that the day care center was already filled.

TABLE 27. Evaluation of Child Care in Day Care Centers
(N=323)

Evaluation	Number	Percent
General positive comment	197	61.1%
General negative comment	21	6.5
Child too young for services	11	3.4
Child too old for services	17	5.3
Transportation problem	11	3.4
Language problem	3	0.9
Center hours do not fit work schedule	12	3.7
Center already filled	36	11.1
Center too expensive	15	4.6

The above responses should be examined with caution. Only those who had experience with a day care center, based on enrolling or trying to enroll a child, were asked to evaluate day care. The other respondents--mothers who did not try to enroll their child because they knew the center was already filled, or because the center only accepted children of certain ages--were not asked to evaluate day care. Thus, the true number of negative responses is probably underestimated in Table 27.

The responses to the day care questions less often were favorable than the responses to the health care questions. While a majority of those mothers whose children were provided with day care liked the service, half of the respondents expressed a need for day care for their children. Since many of the mothers who said they did not need day care have children who are of school age, the true need for day care would appear to encompass well over half of the migrant parents with children of preschool age.

Family Services

Approximately one-quarter of the respondents reported that a situation arose during the past year in which they were unable to care for their children due to accidents or sickness. The findings on the need for family services while the mother was ill or incapacitated are reported in Table 28.

TABLE 28. Need for Family Services* within the Past Year
(N=722)

Need for Family Services	Number	Percent
Family services needed	209	28.9%
Family services not needed	513	71.1

*The need for family services is understood to arise when the mother is ill or incapacitated.

As shown in Table 29, a majority of mothers in need of family services were living at home base at the time the need arose.

TABLE 29. Place of Residence When Need for Family Services Arose
(N=194)

Place of Residence	Number	Percent
Home Base	113	58.3%
In-stream	81	41.7

A plurality of the respondents, 43.4%, received help from relatives in caring for their children. Table 30 shows that only 5.3% of the mothers received help from an agency in caring for their children, while 16.9% of the mothers depended on their older children to take care of themselves and to tend their younger siblings.

TABLE 30. Arrangements for Child Care while Mother Incapacitated
(N=189)

Arrangements	Number	Percent
Friends	25	13.2%
Family (including relatives)	82	43.4
Agency	10	5.3
No one	32	16.9
Miscellaneous	40	21.2

Also, only 5.4% of the respondents received help with chores from an agency, while a majority, 61.1%, received help from relatives, as indicated by the data in Table 31.

TABLE 31. Arrangements to Help with Chores While Mother Incapacitated (N=185)

Arrangements	Number	Percent
Friends	24	13.0%
Family (including relatives)	113	61.1
Agency	10	5.4
No one	20	10.8
Miscellaneous	18	9.7

These responses indicate that Family Services are very seldom utilized by migrants. In general, migrants are much more likely to depend on relatives for help when the mother is incapacitated. State or local agencies, which customarily provide Family Services in these stituations, are either unaware of the migrant mother's plight or are unable to help. In addition, the mobility of migrants and the limited outreach activities of some social service agencies make it likely that migrant mothers are unaware that such services are available to them. On the other hand, it is possible that migrants would be reluctant to use agency-provided Family Services were they made available to them. As a result, the migrant family tends to rely on its own limited resources in such situations.

Educational Services

Mothers were asked whether their children received any special educational services at school. The interviews were held in the early fall, before many children were enrolled in school. Therefore, many children had not been in school since the preceding spring, and the parents reported that they had no children in school "at present." As a result, the total number of respondents to this question was only 321.

Of those mothers who responded, almost half, 46.1%, reported that their children received no special educational services. The largest proportion of children receiving a service were provided with counseling. About equal proportions of children received special remedial or small group classes, and other services, such as vocational education and special education for handicapped, hyperactive, and learning impaired students. Only 7.5% of the mothers reported that their children received bilingual education. The information on supplemental educational services is presented in Table 32.

TABLE 32. Types of Supplemental Educational Services Received
(N=321)

Educational Service Received	Number	Percent
Special classes*	41	12.8%
Counseling	54	16.8
Bilingual education	24	7.5
Tutoring	7	2.2
Other**	47	14.6
None	148	46.1

*"Special classes" refers to small group or individualized supplemental or remedial instruction.

**"Other" includes services such as vocational education and programs for children who are handicapped, hyperactive, or have learning impairments.

Services were divided between those who received services only at home base, 42.7%, and those who received them only in-stream, 34.1%. As shown in Table 33, a majority of children received services at home base; about one-fourth of the children received services both at home base and in-stream.

TABLE 33. Place of Residence When Supplemental Educational Services Are Received
(N=129)

Place of Residence	Number	Percent
Home base	55	42.7%
In-stream	44	34.1
Both	30	23.2

Table 34 shows that close to one-half of the mothers, 42.6%, felt their children needed special services in school.

TABLE 34. Need for Supplemental Educational Services*
(N=497)

Need	Number	Percent
Services needed	212	42.6%
Services not needed	285	57.4

*"Supplemental educational services" refers to counseling, bilingual education, tutoring, supplemental instruction, vocational education, and special services for children who are handicapped or have learning disabilities.

Miscellaneous Services

Additional questions were asked concerning services other than those covered above for which migrants are usually eligible or are thought to need. These services included family planning, free clothing for their children, and free meals in school.

Family Planning. - As Table 35 shows, just under half, 45.9%, of the mothers received help with family planning.

TABLE 35. Help with Family Planning Received
(N=726)

Family Planning Service	Number	Percent
Help received	333	45.9%
Help not received	393	54.1

Table 36 shows that about one-third of those who did not receive help would like help with family planning. The number of respondents for Table 36 includes several people who had not answered the preceding question.

TABLE 36. Need for Help with Family Planning within the Past Year
(N=420)

Need for Family Planning Help	Number	Percent
Help needed	145	34.5%
Help not needed	275	65.5

Many of the mothers who reported that they did not desire family planning help were past the child-bearing age. If women past the child-bearing age were discounted from the sample, then the actual proportion of women who desired family planning help would be somewhat greater than 34.5% indicated in Table 36. Despite the widespread use of migrant health clinics and other sources of health care, approximately 20% of the women questioned, 145 out of 750 respondents, reported that they would like to have family planning help but have not received it. Pregnancy temporarily eliminates the mother's income and infants are a drain on the family's already limited economic resources. As a result, the unmet need for family planning among migrant mothers is especially important to the farmworker family.

Free Clothing. - Approximately one-third of the mothers said their children had received free clothing within the past year, as shown in Table 37.

TABLE 37. Free Clothing Received within the Past Year
(N=729)

Clothing Service	Number	Percent
Clothing received	260	35.7%
Clothing not received	469	64.3

Table 38 indicates that three-quarters of this clothing was provided by agencies, and the rest came from friends, relatives, and miscellaneous sources.

TABLE 38. Source of Free Clothing Received
(N=260)

Source	Number	Percent
Friends	28	10.8%
Relatives	14	5.4
Agency	195	75.0
Other	23	8.8

Agencies thus appear to be the most often used source in distributing free clothing to migrant children. Nevertheless, agencies provided clothing to less than one-third of the families in the sample, which is a low figure when one considers the widespread availability of free clothing distribution to poor families.

Free Meals in School. - Mothers were asked if their children received free breakfasts or lunches while in school, either at home base or while in-stream. These data are presented in Table 39 to 42. Table 39 shows that about half of the children received free breakfasts at home base schools.

TABLE 39. Free Breakfast Received in Home Base School
within the Past Year
(N=536)

Breakfast Service	Number	Percent
Breakfast received	275	51.3%
Breakfast not received	261	48.7

Almost three-quarters of the migrant students received free lunches at home base schools, as shown in Table 40.

TABLE 40. Free Lunch Received in Home Base School within the Past Year (N=545)

Lunch Service	Number	Percent
Lunch received	397	74.1%
Lunch not received	148	25.9

Table 41 shows that a little over half, 56.2%, received free breakfasts in-stream.

TABLE 41. Free Breakfast Received in School In-stream within the Past Year (N=512)

Breakfast Service	Number	Percent
Breakfast received	288	56.2%
Breakfast not received	224	43.8

The data in Table 42 show that about two-thirds of the migrant students received free lunches while in-stream.

TABLE 42. Free Lunch Received in School In-stream within the Past Year (N=514)

Lunch Service	Number	Percent
Free lunch received	352	68.5%
Free lunch not received	162	31.5

Thus, free lunch programs at home base were the most utilized of the free school meal programs, followed by free lunch in-stream. Free breakfasts were received by about half the school children both at home base and in-stream.

Problems in Raising Children and Desired New Services

Respondents were asked the major problems they faced in raising children in-stream and at home base, and what new child welfare services they would like to have made available to them. These questions were open-ended, and respondents were free to list as many problems or services as they wished. However, in coding the responses, problems or services that did not directly pertain to child welfare, such as finding employment, were coded as "other." Miscellaneous problems or services that were very infrequently mentioned were also coded as "other."

The major problems faced at home base are shown in Table 43. Housing was, by far, the most frequently mentioned problem. One out of every four respondents cited housing as a problem. A substantial percentage of respondents, 17.1%, reported that they faced no major problems while at home base, but 11.9% reported difficulties with schools. Day care was mentioned infrequently as a problem at home base. About one-quarter of the respondents mentioned other problems, including difficulties finding employment and paying bills, and other problems not directly related to child welfare services. Miscellaneous problems related to child-rearing, such as lack of time to be with the children, were also mentioned.

TABLE 43. Major Problems Respondent Faces Raising Children at Home Base (N=949*)

Major Problem	Number	Percent
Caring for children during the day	76	8.1%
Health care	56	5.9
Buying food	34	3.6
Problems with schools	114	12.0
Housing	240	25.3
Recreation	18	1.9
Other	247	26.0
None	164	17.2

*N equals more than total number of respondents because some respondents mentioned more than one problem.

The major problems raising children in-stream are shown in Table 44. The most frequently mentioned problem is housing, mentioned by one-fifth of the respondents. Day care and schools were the next most frequently cited areas of difficulty and included such matters as a lack of continuity, a lack of bilingual education, children being out of school during school hours, and so forth. Again, the miscellaneous category included a number of respondents who stated that a lack of jobs and money was the greatest problem they faced while in-stream.

TABLE 44. Major Problems Respondent Faces Raising Children In-stream (N=957*)

Major Problem	Number	Percent
Caring for children during the day	151	15.8%
Health care	70	7.3
Buying food	36	3.8
Problems with schools	106	11.1
Housing	197	20.6
Recreation	52	5.4
Other	254	26.5
None	91	9.5

*N equals more than total number of respondents because some respondents mentioned more than one problem.

The major problems raising children in-stream thus differ from the major problems at home base. In-stream, finding a suitable place for the children to live in each new location is the major problem faced by these farmworkers. Since most of the women work in the fields during the day, day care and education for school-aged children are also issues of concern. While in-stream, migrant parents are obviously preoccupied primarily with very basic problems: a decent place to live, care for the children while the mother works, and enrolling children in schools. At home base, on the other hand, the problems are somewhat different, and a sizeable proportion of parents report no major problems at all. Day care appears to be much less problematic at home base. The major problem faced by migrant parents at home base is housing, which doubtless reflects the low income of most farmworker families during the off-season.

Respondents were asked what new child welfare services they would like to have provided. The most frequently desired new services were better health care for their children, better education, and infant day care. Once again, a number of respondents mentioned services indirectly related to child welfare, such as better employment referrals and unemployment compensation, as well as a number of other services that were mentioned too infrequently to be meaningfully tabulated. The responses about desired new services are presented in Table 45.

TABLE 45. New Child Welfare Services Desired by Respondent (N=1,079*)

Desired New Services	Number	Percent
Day care for infants	150	14.0%
Expanded day care hours	70	6.5
Better health care	167	15.6
More help buying food and obtaining food stamps	68	6.3
Educational reforms	151	14.1
Housing aid	105	9.3
Better recreational facilities	98	9.1
Other	196	18.3
None	74	6.8

*N equals more than total number of respondents because some respondents mentioned more than one new service.

The new services the parents would like do not necessarily correspond to the services already received. For instance, in the earlier questions on health care, it was found that health care was obtained almost every time it was needed, and the evaluations of the care received were laudatory. Nevertheless, better health care was first among the services the parents desired for their children. Many children, however, had probably received care only in response to an accident or illness. The parents, in expressing their concern for better health care, may desire more preventive care services. The other most frequently mentioned new services--education and day care--have also been reported as problem areas at home base. Education also was found to be a problem area with migrants who are in-stream.

Services By Stream

An attempt was made to determine whether or not significant differences exist between the three major streams--West Coast, mid-continent, and East Coast--in which the migrants travel. The states sampled in the West Coast stream were California and Washington; the states sampled in the mid-continent stream were Colorado, Illinois, Iowa, Michigan, and Texas; and the states sampled in the East Coast stream were Florida, North Carolina, New Jersey, and New York.* The total N for the West

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*While respondents were classified by stream according to the state in which the interview was held, some respondents probably crossed streams at some point during their migration. For instance, a respondent in New Jersey might have migrated from Texas. Thus, the grouping of data by stream represents only an approximation of the actual composition of migrant streams.

Coast stream was only 77, and this may present some problems in the analysis. In order to simplify this section of the analysis, the only questions used will be those that deal directly with the need and use of the various services.

Table 46 shows that the need for health care differed somewhat between streams. Health care was reported to be needed somewhat more frequently in the mid-continent stream than in the West Coast or East Coast streams.

TABLE 46. Need for Health Care within the Past Year, by Stream (N=722)

Need for Service	West Coast N	West Coast %	Mid-continent N	Mid-continent %	East Coast N	East Coast %
Health care needed	37	48.0%	205	59.0%	149	50.2%
Health care not needed	40	52.0	143	41.0	148	49.8
TOTAL	77	100.0%	348	100.0%	297	100.0%

When needed, health care was received in over 90% of the cases, regardless of stream. This is shown in Table 47. Thus, the availability of health care appeared not to be a problem in any of the three streams.

TABLE 47. Health Care Received within the Past Year, by Stream (N=390)

Service	West Coast N	West Coast %	Mid-continent N	Mid-continent %	East Coast N	East Coast %
Health care received	33	91.7%	191	93.2%	137	91.9%
Health care not received	3	8.3	14	6.8	12	8.1
TOTAL	36	100.0%	205	100.0%	149	100.0%

Table 48 shows that day care was slightly more frequently reported to be needed in the West Coast and East Coast streams than in the mid-continent stream. Day care thus appears to be available to slightly more mothers in the mid-continent stream than elsewhere.

TABLE 48. Need for Day Care within the Past Year, by Stream
(N=653)

	Stream					
Need for Service	West Coast		Mid-continent		East Coast	
	N	%	N	%	N	%
Day care needed	40	56.3%	173	58.1%	124	56.3%
Day care not needed	31	43.7	125	41.9	160	43.7
TOTAL	71	100.0%	298	100.0%	284	100.0%

The need for educational services is shown in Table 49. Respondents in the West Coast states tended to report that their children needed special help in education much more frequently than those in either mid-continent or East Coast states. This could well be a result of a greater knowledge of the school system by parents on the West Coast, and a greater awareness of supplemental educational services that can or should be available.

TABLE 49. Need for Supplemental Educational Services within the Past Year, by Stream
(N=496)

	Stream					
Need for Service	West Coast		Mid-continent		East Coast	
	N	%	N	%	N	%
Educational services needed	25	64.1%	91	58.1%	95	38.3%
Educational services not needed	14	35.9	118	54.3	153	61.7
TOTAL	39	100.0%	209	100.0%	248	100.0%

The use of family planning help also differs across stream, as shown in Table 50. Respondents in the mid-continent states reported much more frequently that they used family planning help than either the West Coast or East Coast respondents.

TABLE 50. Family Planning Help Received within the Past Year, by Stream (N=721)

	Stream					
Service	West Coast		Mid-continent		East Coast	
	N	%	N	%	N	%
Family planning help received	26	33.3%	194	55.9%	107	36.3%
Family planning help not received	52	66.7	154	44.1	188	63.7
TOTAL	78	100.0%	348	100.0%	295	100.0%

As a result, the need for family planning among those who had not received help was less in the mid-continent stream than in the other two streams. Table 51 presents this information.

TABLE 51. Need for Family Planning Help within the Past Year, by Stream (N=420)

	Stream					
Need for Service	West Coast		Mid-continent		East Coast	
	N	%	N	%	N	%
Family planning help needed	16	31.8%	42	24.7%	87	43.9%
Family planning help not needed	36	68.2	128	75.3	111	56.1
TOTAL	52	100.0%	170	100.0%	198	100.0%

In addition, more children received free clothing in mid-continent states than in either the West Coast or the East Coast streams (21.8% and 30.3%, respectively).

TABLE 52. Free Clothing Received within the Past Year, by Stream (N=724)

	Stream					
Service	West Coast		Mid-continent		East Coast	
	N	%	N	%	N	%
Free clothing received	17	21.8%	150	42.6%	89	30.3%
Free clothing not received	61	78.2	202	57.4	205	69.7
TOTAL	78	100.0%	352	100.0%	294	100.0%

The sources of free clothing varied by stream, as shown in Table 53. Furthermore, the majority of children who received free clothing in the mid-continent stream and East Coast streams received it from agencies, while children in the West Coast stream tended to obtain their free clothing from friends or relatives. The various sources of free clothing by stream are shown in Table 53.

TABLE 53. Source of Free Clothing Received within the Past Year, by Stream (N=254)

	Stream					
Service	West Coast		Mid-Continent		East Coast	
	N	%	N	%	N	%
Friends	3	17.6%	18	12.1%	6	6.7%
Relatives	3	17.6	6	4.0	1	1.1
Agency	8	47.2	119	80.5	67	75.3
Other	3	17.6	5	3.4	15	16.9
TOTAL	17	100.0%	148	100.0%	89	100.0%

Substantial differences exist in the receipt of free breakfasts in school while at home base. Table 54 shows that only about one-third of the children in the West Coast stream received free breakfasts at home base. Less than half of the children in the mid-continent stream and more than half of the children in the East Coast stream received free breakfasts.

TABLE 54. Free Breakfast Received at Home Base School
within the Past Year, by Stream
(N=535)

Service	Stream					
	West Coast		Mid-continent		East Coast	
	N	%	N	%	N	%
Free breakfast received	16	32.0%	104	46.6%	154	58.8%
Free breakfast not received	34	68.0	119	53.4	108	41.2
TOTAL	50	100.0%	223	100.0%	262	100.0%

By contrast, almost equal numbers of children receive free lunches at home base. Table 55 shows that about three-quarters of the children receive free lunches at home base, regardless of stream.

TABLE 55. Free Lunch Received at Home Base School
within the Past Year, by Stream
(N=546)

Service	Stream					
	West Coast		Mid-continent		East Coast	
	N	%	N	%	N	%
Free lunch received	35	70.0%	179	76.5%	186	71.0%
Free lunch not received	15	30.0	55	23.5	76	29.0
TOTAL	50	100.0%	234	100.0%	262	100.0%

The receipt of free breakfast and free lunch differs by stream while migrants are in-stream. The smallest percentage (39.5%) of those receiving free breakfasts was on the West Coast, and the largest percentage (61.1%) was on the East Coast, while more than half (53.8%) received free breakfast while traveling in the mid-continent stream, as shown in Table 56. The percentages of children receiving free breakfasts while in-stream correspond roughly to the percentages of children receiving free breakfasts while at home base.

TABLE 56. Free Breakfast Received at In-stream School
within the Past Year, by Stream
(N=510)

Service	West Coast N	West Coast %	Mid-continent N	Mid-continent %	East Coast N	East Coast %
Free breakfast received	17	39.5%	113	53.8%	157	61.1%
Free breakfast not received	26	60.5	97	46.2	100	38.9
TOTAL	43	100.0%	210	100.0%	257	100.0%

Free lunch in-stream, however, does not follow this pattern. Table 57 shows that slightly more than half (52.4%) of the children on the West Coast received free lunches in school, about three-quarters received it mid-continent, and about two-thirds received it on the East Coast.

TABLE 57. Free Lunch Received at In-stream School
within the Past Year, by Stream
(N=511)

Service	West Coast N	West Coast %	Mid-continent N	Mid-continent %	East Coast N	East Coast %
Free lunch received	22	52.4%	162	76.0%	166	64.8%
Free lunch not received	20	47.6	51	24.0	90	35.2
TOTAL	42	100.0%	213	100.0%	256	100.0%

The West Coast is significant in having the smallest proportion of the sample that received free meals in school except for free lunches at home base. It should be noted that the sample size for the West Coast is small, so these figures may not accurately depict meal services for the West Coast stream as a whole. No pattern emerges for the other two streams.

The major problems the mothers face raising their children at home base differ by stream, as shown in Table 58. For both West Coast and East Coast respondents, the major problem is housing, reported by 29% and 24.6%, respectively. By contrast, housing was mentioned by only 4.6% of the respondents in the mid-continent stream.

TABLE 58. Major Problems Respondent Faces Raising Children at Home Base, by Stream
(N=849*)

	Stream					
Problem	West Coast		Mid-continent		East Coast	
	N	%	N	%	N	%
Caring for children during the day	11	12.6%	29	8.4%	36	8.8%
Health care	5	5.7	20	5.8	28	6.7
Buying food	2	2.3	18	5.2	13	3.1
Problems with schools	14	16.1	40	11.5	57	13.7
Housing	26	29.9	16	4.6	102	24.6
Recreation	4	4.7	6	1.7	8	1.9
Other	19	21.8	141	40.6	91	21.9
None	6	6.9	77	22.2	80	19.3
TOTAL	87	100.0%	347	100.0%	415	100.0%

*N equals more than total number of respondents because some respondents mentioned more than one problem.

Housing, thus, is a serious problem on the West Coast and East Coast, but is much less of a problem in the mid-continent stream. Important differences between streams are also reflected in the "none" and "other" categories. Only 6.9% of the West Coast respondents reported that they had no major problems raising children at home base, while about one-fifth of the respondents in the other streams reported no problems. In addition, about two- fifths (40.6%) of those interviewed in the mid-continent stream mentioned other problems not directly related to child welfare services, including problems with employment, or matters noted too seldom to be coded. In the West Coast and East Coast streams, only about 20% of those surveyed mentioned other problems.

Table 59 presents the major problems the respondents faced raising children while in-stream. Again, housing was the problem mentioned most often on the West Coast (33.6%) and the East Coast (29.2%), but was seldom mentioned in mid-continent.

TABLE 59. Major Problems Respondent Faces Raising Children In-stream, by Stream (N=840*)

Problem	West Coast N	West Coast %	Mid-continent N	Mid-continent %	East Coast N	East Coast %
Caring for children during the day	16	16.3%	91	21.1%	37	9.0%
Health care	3	3.1	41	9.5	26	6.4
Buying food	3	3.1	24	5.6	9	2.2
Problems with schools	17	17.3	46	10.6	41	10.0
Housing	33	33.6	38	8.8	120	29.3
Recreation	1	1.0	18	4.2	32	7.8
Other	23	23.5	113	26.1	118	28.7
None	2	2.1	61	14.1	27	6.6
TOTAL	98	100.0%	432	100.0%	410	100.0%

*N equals more than total number of respondents because some respondents mentioned more than one problem.

The largest category in the mid-continent stream was "other" (26.1%), which was the second largest category in the other two streams. Again, this category included a large number of responses citing problems in finding employment, earning a suitable income, and so forth. Day care was mentioned frequently in the mid-continent stream (21.1%) and the West Coast stream (16.3%), but much less frequently in the East Coast stream (9.0%). Day care would thus appear to be less of a problem while in-stream on the East Coast than elsewhere. Finally, respondents in the mid-continent stream were much more likely to respond that they had no major problems in-stream (14.1%) than respondents in the other two streams.

When mentioning what new services they would like, there were few major differences by stream, as shown in Table 60.

TABLE 60. New Child Welfare Services Respondent Desires, by Stream (N=1,060*)

Desired Service	West Coast N	West Coast %	Mid-continent N	Mid-continent %	East Coast N	East Coast %
Day care for infants	28	24.3%	76	18.3%	43	8.2%
Expanded day care hours	7	6.1	19	4.5	43	8.2
Better health care	17	14.8	53	12.6	96	18.3
More help buying food and obtaining food stamps	6	5.2	20	4.8	42	8.0
Educational reforms	13	11.3	59	14.1	75	14.2
Housing aid	6	5.2	21	5.0	77	14.6
Better recreational facilities	16	13.9	32	7.6	41	7.8
Other	21	18.3	98	23.3	77	14.6
None	1	0.9	41	9.8	32	6.1
TOTAL	125	100.0%	419	100.0%	526	100.0%

*N equals more than total number of respondents because some respondents mentioned more than one new service.

The primary difference is in day care; fewer respondents in the East Coast stream (8.2%) desired day care for infants than respondents in the mid-continent (18.3%) or West Coast (24.3%) streams. West Coast respondents expressed a desire for children's recreational facilities nearly twice as often as mid-continent or East Coast mothers. West Coast respondents were also much more likely than others to say that they desired new services.

In conclusion, it appears difficult to characterize any one stream as being particularly "good" or "poor" in terms of delivery of services to migrants. Families in the mid-continent stream more often reported receiving free clothing and family planning help, and the children generally received free meals in school more often. In addition, housing was mentioned as a problem less frequently in the mid-continent stream. Other differences between streams, however, were not at all distinct. An analysis of variations between states would probably be a more fruitful method of analysis than comparison of streams. Many of the services studied are administered on a state level and service delivery differs significantly from state to state. In addition, many migrants cross streams at some point in their travels, and so distinctions in service delivery between streams become blurred. The data presented here indicate that there is little reason to assume that all the states in any one stream provide consistently better or worse services than states in another stream. In short, there are no verifiable trends in quality or extent of service delivery by migrant stream.

Services by Settled-Out Status

An analysis was also made of the same services studied above, comparing need and receipt of services among those who are currently migrating and those who have settled out. Settled-out migrants are those who have left the migrant stream to settle permanently in an area within which they formerly worked. This analysis should provide some evidence as to whether settled-out migrants experience more difficulties in obtaining services than those who are currently migrating. The problems inherent in locating settled-out migrants should be reiterated here. There is no simple, positive way of identifying those rural (or urban) poor who have been migrants in the past. As a result, [illegible] interviewers were asked to speak with individuals who were known by them or by others to be former migrants who had settled-out. The sample of settled-out migrants was small (N=107), and was not random. As a result, inferences about settled-out migrants as a whole should not be made from these data.

First, the need for health care differed slightly between settled-outs and current migrants. Current migrants reported a need for health care slightly more often than did settled-outs, as seen in Table 61.

TABLE 61. Need for Health Care within the Past Year, by Migratory Status (N=723)

Need for Service	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Health care needed	53	50.0%	339	55.0%
Health care not needed	53	50.0	278	45.0
TOTAL	106	100.0%	617	100.0%

Table 62 shows that groups, however, received health care in the vast majority of cases and in equal proportions (92.3% for both groups).

TABLE 62. Health Care Received within the Past Year, by Migratory Status (N=391)

Service	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Health care received	48	92.3%	313	92.3%
Health care not received	4	7.7	26	7.7
TOTAL	52	100.0%	339	100.0%

The information in this table demonstrates that the settled-outs sampled did not experience a greater lack of health care services than did current migrants. Settled-outs reported a need for day care somewhat more often than did current migrants (59.4% and 50.0%, respectively). This is seen in Table 63.

TABLE 63. Need for Day Care within the Past Year, by Migratory Status (N=651)

Need for Day Care	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Day care needed	60	59.4%	275	50.0%
Day care not needed	41	40.6	275	50.0
TOTAL	101	100.0%	550	100.0%

The final major service, supplemental educational services in school, was needed by both groups about equally. Table 64 shows that about two-fifths of each group (40.0% of the settled-outs and 43.3% of the current migrants) reported that their children needed special help in school.

TABLE 64. Need for Supplemental Educational Services within the Past Year, by Migratory Status (N=496)

Need for Service	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Educational services needed	32	40.0%	180	43.3%
Educational services not needed	48	60.0	236	56.7
TOTAL	80	100.0%	416	100.0%

The other services studied also revealed some differences between the two groups. Settled-outs tended to receive help with family planning somewhat more often (50.9%) than current migrants (42.3%), as seen in Table 65.

TABLE 65. Family Planning Help Received within the Past Year,
by Migratory Status
(N=712)

Service	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Family planning help received	54	50.9%	265	42.7%
Family planning help not received	52	49.1	341	56.3
TOTAL	106	100.0%	606	100.0%

The need for family planning help was mentioned less often among the settled-outs (29.8%) than among current migrants (35.3%). Table 66 indicates the extent of the need for family planning help.

TABLE 66. Need for Family Planning Help within the Past Year,
by Migratory Status
(N=420)

Need for Service	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Family planning help needed	17	29.8%	128	35.3%
Family planning help not needed	40	70.2	235	64.7
TOTAL	57	100.0%	363	100.0%

Fewer settled-outs (22.1%) received free clothing than did current migrants (36.6%), as shown in Table 67.

TABLE 67. Free Clothing Received within the Past Year,
by Migratory Status
(N=714)

Service	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Free clothing received	23	22.1%	223	36.5%
Free clothing not received	81	77.9	387	63.5%
TOTAL	104	100.0%	610	100.0%

Furthermore, the settled-outs were much more likely to have received free clothing from friends (39.1%) whereas most current migrants (80.4%) received free clothing from agencies. The sources of free clothing are presented in Table 68.

TABLE 68. Source of Free Clothing Received within the Past Year, by Migratory Status (N=247)

Service	Settled-out		Currently migrating	
	N	%	N	%
Friends	9	39.1%	18	8.0%
Relatives	1	4.3	7	3.1
Agency	12	52.3	180	80.4
Other	1	4.3	19	8.5
TOTAL	23	100.0%	224	100.0%

Free meals at school were received by almost equal proportions of settled-out and current migrants. About half of the children in each group received free breakfasts at school, but slightly more of the settled-out migrants received breakfast, as shown in Table 69.

TABLE 69. Free Breakfast Received at School within the Past Year, by Migratory Status (N=536)

Service	Settled-out		Currently migrating	
	N	%	N	%
Free breakfast received	45	55.5%	230	50.6%
Free breakfast not received	36	44.5	225	49.4
TOTAL	81	100.0%	455	100.0%

Free lunches were provided to two-thirds of the settled-out migrant students and to three-fourths of the current migrant students, as indicated in Table 70.

TABLE 70. Free Lunch Received at School within the Past Year, by Migratory Status
(N=537)

Service	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Free lunch received	55	67.9%	340	75.6%
Free lunch not received	26	32.1	116	24.4
TOTAL	81	100.0%	456	100.0%

When asked their major problems raising children, the two groups did not differ markedly, although there were a few differences of note. The major problems in raising children are reported in Table 71.

TABLE 71. Major Problems Respondents Face Raising Children, by Migratory Status
(N=935*)

Problem	Migratory Status			
	Settled-out		Currently migrating	
	N	%	N	%
Caring for children during the day	31	20.5%	104	13.9%
Health care	17	11.2	51	6.9
Buying food	2	1.3	34	4.6
Problems with schools	10	6.6	92	12.4
Housing	47	31.1	150	20.2
Recreation	4	2.6	41	5.5
Other	30	20.0	231	31.0
None	10	6.7	41	5.5
TOTAL	151	100.0%	744	100.0%

*N equals more than total number of respondents because some respondents mentioned more than one problem.

Settled-out migrants mentioned day care as a problem somewhat more frequently than did current migrants. Almost a third of the settled-outs mentioned housing as a problem, probably because of their low incomes combined with their ineligibility for living in migrant housing.

The responses of settled-outs and current migrants were very similar with regard to desired new services, as seen in Table 72. Day care for infants, better health care, and better housing were the desired new services mentioned most often by both groups of respondents.

TABLE 72. New Child Welfare Services Respondent Desires, by Migratory Status
(N=1,036*)

	Migratory Status			
Desired Service	Settled-out		Currently migrating	
	N	%	N	%
Day care for infants	23	16.9%	113	12.8%
Expanded day care hours	9	5.8	60	6.8
Better health care	25	16.3	142	16.0
More help buying food and obtaining food stamps	13	8.4	55	6.2
Educational reforms	17	11.0	131	14.9
Housing aid	20	13.0	82	9.3
Better recreational facilities	13	8.4	66	7.4
Other	22	14.4	173	19.5
None	9	5.8	63	7.1
TOTAL	151	100.0%	885	100.0%

*N equals more than total number of responses because some respondents mentioned more than one new service.

In conclusion, it appears that the services received by settled-out migrants do not differ markedly from the services received by current migrants. Housing and day care are mentioned more often as problems among settled-outs than among current migrants. Settled-outs receive free clothing less often than do current migrants. Other needs, though, were quite similar for both groups. These data do not provide much evidence to support the hypothesis that settled-outs experience difficulty in obtaining services that are available to current migrants and long-term residents of the area. In fact, this study indicates that settled-out migrants are not only eligible for the same services available to current migrants but also appear to be aware of the procedures required to obtain those services.

PART FOUR

ANALYSIS OF SELECTED MIGRANT FARMWORK SITES

INTRODUCTION

The following chapters present a detailed, in-depth summary of migrant child welfare in each of the twelve states surveyed. As noted earlier, the states represent both home base and in-stream migrant work areas in each of the three major streams (East Coast, mid-continent, and West Coast). Also, states which have both large and small concentrations of migrants are represented.

For each state, the topic areas of social services, child care, health, and education are discussed at the state and local levels. The major emphasis is on local level service provision in the county which has the largest migrant population in each survey state. This emphasis allowed a thorough analysis of the migrant child welfare situation in areas of largest migrant concentration. However, services in these counties are not necessarily representative of services provided throughout the rest of the state, nor is information obtained at the state level representative of services statewide, or of other states in that stream.

Information presented is based on personal interviews made during the site visits to the states and questionnaire responses by state and local service providers including state and local education agencies, social services (especially protective services and day care), migrant day care centers, farmworker organizations, state migrant affairs offices, migrant health clinics, and other migrant advocates, such as legal aid personnel. The administrative structure and coordination of services in the state is discussed. There also is an assessment of need for all child welfare services in each state, which includes the number of children reached by the services. Thus, these reports contain a detailed examination of how migrant children are served in high impact migrant regions in selected states from each migrant stream.

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CHAPTER I

CALIFORNIA: IMPERIAL AND FRESNO COUNTIES

Contrary to popular opinion, California is a state with relatively few migrant farmworkers. Agricultural workers in the state, known through the efforts of the United Farm Workers unionization drives, are almost entirely seasonal farmworkers who do not leave their own locales to pursue work. In addition, the harvest of many of the crops which once required hand labor has now been mechanized. Cotton, for example, a staple of the Fresno County economy, was harvested until the early 1970's by a large migrant farm labor force that traveled through the San Joaquin Valley of central California. Today, however, migrant labor in California is limited to a small number of workers who come to the state from Texas under previously arranged work contracts. Also, a small number of families live in the Imperial Valley in the southern part of the state--the last of a large migrant stream that migrated seasonally from the valley to the Salinas-San Jose area to harvest grapes and walnuts, now done chiefly by seasonal farmworkers.

Imperial County comprises almost all of the Imperial Valley agricultural area. The Valley, most of which is below sea level, is the second lowest area in the nation. Despite its blistering desert climate, it produces just over one-half billion dollars per year in agricultural products, due to intensive irrigation. Over $150 million of this total is in vegetable crops, which require hand tending and harvesting, creating a large-scale agricultural labor market in the area. In fact, Imperial County is one of the five top agricultural counties in the United States.

The county is also adjacent to the Mexican border and is subject to a massive daily flow of domestic and agricultural workers across the border in both directions. U.S. residents are drawn by the lower prices for goods and services on the Mexican side. Mexican citizens cross to the U.S. side, both legally and illegally, seeking employment, and many continue northward into the heart of California. The considerable admixture of nationalities, lifestyles and purposes makes it difficult, if not impossible, to distinguish the "true" or current migrant, as definable for the other states in this study, from the illegal alien, the seasonal, and the occasional farmworker.

Like most of California, Imperial County in extreme southern California does not have a clearly defined migrant population. Rather, Spanish-speaking farm hands work for various employers around the county, in nearby counties, or, in a few cases, upstate. The total county population is 75,000, including an estimated 35,000 farmworkers. There are few identifiable out-of-state migrants, either entering the county or migrating northward.

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In Fresno County, the lower portion of the San Joaquin Valley of central California, these transitions in the makeup of the farmworker population are a major impediment to service and recognition of need. When mechanization removed much of the demand for farm labor, the large number of migrant farmworkers, who became unemployed seasonal farmworkers residing permanently in the county, filled the welfare rolls. An influx of aliens, both legal and illegal, has increased the supply of workers and made economic conditions for farmworkers even worse. The drought of 1976-77 intensifies this situation in a state which already has inordinately high unemployment, financial assistance, and social service program funding burdens. Within this mix, the plight of the "true" migrant is hard to define, but many of the difficulties in providing services to the total "farmworker/employed" population are aggravated in the case of the migrant.

Many of the farmworkers in California are settled-out migrants and experience the same problems as current migrants. For example, the state operates a network of migrant labor camps that were originally designed to accommodate housing needs of farmworkers for only those periods of the year when most of the harvesting was done. Known as "flash peak camps," they are inhabited in many areas by persons who no longer migrate but have nowhere else to live. The camps, ironically, are open only part of the year, and evict dwellers who then must find other shelter locally during the remaining months of the year.

Services and Needs in Imperial County

Social Services

Migrants and other farmworkers in Imperial County were not identified as such in case records by the county welfare agency, thus creating problems in determination of need for services. One of the greatest problems in providing services to farmworker families is day care placement. Of the ten private day care centers in the county, and the 20-25 private day care homes serving three to ten children each, none meet the hours of care required by farmwork. Further, of the 120 foster home placements in the county, it is doubtful if any are migrant children. Of the 15 children served by the county in adoption proceedings last year, none were migrants. Homemaker services are provided only for the aged, disabled, and blind; of 230, none were migrants in 1976. There are no group home services. There are no maternity homes nor institutional protective services care for children in the county. Of the 200 protective services cases last year, the number of migrants was unknown, but because referrals were usually from schools, and migrants attend school only briefly in the area, it is unlikely that many migrants were referred. Of the 15 to 20 children placed in the county shelter located outside of the town in a complex with the detoxification and juvenile detention centers, the welfare office was not sure if any were migrants. In-the-home care for children is a service typically provided to those receiving AFDC, although others are eligible as well. About 40 cases a year are handled; but, again, it was indicated that it is unlikely that migrants were among those served.

The Imperial County Welfare Department has no staff specifically assigned to serve migrants and no contracts with organizations to serve migrant children. The only training for service to migrants was "years ago." There are three former migrants on the department staff, including the Director of Social Services. Of the 125 staff members, 40 are Chicanos; of those, only the Director of Social Services and a caseworker work in a professional capacity. While there are no eligibility differences for migrants, there is screening for citizenship. There have been no rejections on these grounds, as illegal aliens apparently know about the screening and do not apply. No transportation is provided. The only major obstacle to serving migrants, according to the agency respondent, is the brevity of their stay.

Child Care

There is no day care provided in Imperial County through Title I Migrant. Campesinos Unidos, Inc. (CUI), the primary farmworker organization in Imperial County, runs two types of day care programs. One is the Child Development Program, seasonally operating at only one site, but with considerable parent interaction and a college-level staff development program. The other is more conventional day care, operating at several sites on a year-round basis.

The Child Development program has a curriculum developed locally by the head teacher and parents, which is used in conjunction with the curriculum developed by the Southwest Regional Educational Laboratory. InterAmerica Research Associates provides consultation to this program, a Migrant Head Start program grantee, as well as training of parents in nutrition, home care, and infant stimulation.

The Child Development Center has a staff of thirteen for sixty children. Staff members may enroll in local junior college courses taught at the Campesinos Unidos offices each year. Introductory psychology and child development have been taught in the past; management and supervision courses may be added in the future. Two of the staff are already in Child Development Associate (CDA) programs and are near completion of their degree requirements; others are in the process of obtaining the state's CDA certification. The requirements have recently been tightened and now require a minimum number of course credits in early childhood education, in addition to experience.

The center has a part-time nurse, shared with the EOC, who does vision testing and assures that all necessary linkages and referrals for other services are made. A nearby college provides screening for hearing loss. There are also arrangements with private physicians to give the children physical examinations, which include lab work. CUI pays for specialists as needed and has good linkages with the University of California at San Diego Medical School. Medical residents provide specialty care at the center, which lowers costs substantially. A yearly agreement with a local dentist, treating six to eight children during each visit, also benefits the program.

Many local physicians and dentists do not accept Medi-Cal patients. Medi-Cal, California's wide coverage version of Medicaid, is income-determined only and not based on AFDC eligibility as Medicaid often is. Medi-Cal covers medical services that Medicaid does not, such as dental and perinatal care. The CUI center's full-time social worker helps a family apply for Medi-Cal if their child requires hospitalization. Each year, the social worker visits all families of children in the center who have indicated on their enrollment applications that they are not on Medi-Cal, to determine if they are eligible and can begin receiving coverage. Many eligible families are not enrolled in Medi-Cal due to problems of transportation, language, and reluctance to take government money.

For most outpatient care, the center uses the county health clinics. When children are sent to the clinic, their health records, usually retained at the centers, are sent along, filled out, and returned the same day. Records-handling had been a major problem when the center tried to work with the local migrant health clinic several years ago. Files often were not returned, and, on occasion, doctors would not arrive for appointments.

The other CUI program serves 80 children in two centers using Title XX monies, through a contract from the local DSS office, and monies from AB-99, a state program to provide day care to low income families in California. Primarily an infant care program, CUI efforts serve children from one day to three years old. Medical and dental services are provided as needed, usually by taking the child to the doctor of the family's choice. The program runs year-round from 7:00 a.m. to 5:00 p.m., five days per week. No transportation is provided. Less than adequate records have been kept on the operations of the center. There is little educational content to the programs; singing, dressing oneself, and games are typical activities. There has been little staff training in the past and staff turnover has created a problem also, since vacancies cause the centers to be out of compliance with the Federal Interagency Day Care Requirement (FIDCR) staff-child ratio standards until replacements can be found--not always an easy task.

The El Centro Community Action Agency sponsors five Head Start centers, each enrolling twenty children, aged three to five years, approximately half of whom are from farmworker families. Three of the five centers have full day sessions. The other two centers are on half-day schedules due to a large backlog of applications. In 1976, 90%, 45 of the 50 staff, were Mexican American, as were 96% of the enrolled children. There is a very active recruitment campaign, involving newspaper advertisements, posters, pamphlets, and door-to-door solicitation for the two weeks prior to the opening of the centers each year. Transportation and health care are provided. There is one rotating health nurse; and there are contracts with physicians in various parts of the valley to provide care. There was formerly a comprehensive health care contract with the local migrant clinic whose resources were too overloaded to provide adequate service to the program, but this subsequently was discontinued.

The curriculum is developmentally oriented and based on OCD-identified performance standards. OCD uses this locale as a target area for their Early Childhood Education specialists. Staff development is through Head Start supplemental training and outside courses taken during release time each semester. To maintain FIDCR staff-child ratio standards, it is necessary for at least one parent to be at each center full-time, and also to use the help of the WIN program work/study students and other local junior college students. Each Head Start center has a Parent Advisory Council (PAC) with representatives on the very active county PAC, which, in turn, sends representatives to the Title I Migrant PAC.

Using its own funds, the Community Action Program runs a supplementary day care program, which provides additional capacity for their centers, along with the Head Start Program. Some savings are obtained by overlapping staff, but, even with a sliding scale fee system, this part of the program loses money each month. Some of the day care is on a 24-hour basis. Between the two programs, the EOC serves a total of 400 children during the five-month farmwork peak season. One additional component of the program, if funded, will be a center under the state's new AB-99 innovative day care program for low-income persons.

The alternatives to the existing day care programs in Imperial County are that the children are taken to the fields and left in cars; there are rattlesnakes in the fields in this region, posing a serious danger. The risks of exposure are great. One agency respondent indicated that she had contracted rheumatic fever from the dampness and cold in the fields when she was six years old.

Through the day care programs run by CUI, it was indicated that more than 50% of the day care need was met. However, there is a need to keep the program open longer. Each year the center is forced to spend more and more on transportation, leaving fewer funds for operation, and none for expansion. In 1976-77, for example, the necessary insurance to transport children was $1,200 per bus.

Education

California considers eight single- and multi-county regions as LEAs for purpose of the Title I Migrant program. Imperial County is one such region. The county school districts prepare their proposed Title I Migrant programs through the office of the Regional Coordinator. According to the MSRTS, there are an estimated 600 to 700 Title I Migrant eligible children of preschool age, however no Title I Migrant preschool care is provided. The summer 1976 efforts to record the enrollment of eligible children into the MSRTS identified 1,500 eligible children, 700 of whom were not previously in the system. In addition, 2,800 new children were enrolled during the previous year. Child labor is less a problem in this region than in the northern part of the state as there is little paid work children can do.

Three pilot programs in secondary education are being run in the county through the Title I Migrant program. They have work/study slots and vocational counseling, but serve only 75 migrant students out of 850 secondary students enrolled in the county migrant program. Purchase-of-services arrangements had not been initiated as it was felt that they would probably not be approved at the state level.

There are Parent Advisory Councils (PACs) in each district and at the county level, as well. The PACs screen staff to be hired; and the regional PAC has indicated that all staff hired must be bilingual. This county was recently involved in a major bilingual education discrimination suit which has had considerable consequences statewide.

Health

The Imperial County Health Department does not identify migrants or other farmworkers in their records. According to the respondent, the department provides very few services of use to farmworkers. There is a drop-in outpatient clinic, which is not advertised and serves relatively few patients. There are also child health clinics held around the county as part of the Child Health and Disability Prevention (CHDP) program (California's EPSDT), but most migrants in the southern half of the county do not seek the county's help, turning instead to the Migrant Health Clinic in the northern part of the county or to the United Farm Worker's prepaid health plan and clinic in the south. An indication that migrants are in fact served in the CHDP clinics is that attendance declines in the summertime when the migrant stream moves north. Continuity of care for migrants is not a priority. The department very seldom forwards immunization records, although it often receives them from clinics farther north for families who are returning to the area.

There are no service contracts with local doctors. The only contracting by the department is with the EOC for a family planning service. There are no former migrants on the Health Department's staff, although most of the staff is bilingual and claim to understand the characteristics of migrant farmworkers. Twelve of the 15 nurses employed are field nurses, and there is a health educator. The department clinic has one internist, three general practitioners, four part-time nurse-practitioners, and one administrator, who is also a medical doctor. Two satellite clinics each have two nurses one and one-half days per week. A pediatric resident from University Hospital in San Diego is available one day a week. Other consultants come as needed from the hospital, usually bi-monthly, in each of the following specialties: pediatrics, allergy, dermatology, orthopedics, and radiology. The clinic has its own dental clinic with three full-time dentists, a dental surgeon one day a month, and a hygienist three days a month; a laboratory; and X-ray facilities. Transportation is provided with seven vehicles, one radio-equipped. Although outreach has been hampered by recent federal migrant health program budget cuts, which reduced the clinic's funding seven percent for fiscal year 1976-77, at present there are 17 employees in the clinic's state-licensed home health outreach program.

The clinic and schools have never worked together, apparently because school personnel were unaware that the clinic was a CHDP provider. The clinic is the county's sole WIC provider, with 800 slots. The clinic serves nearly one hundred persons per day and is open five and one-half days per week. Because of the patient overload, the limited services available, and the overriding problems of alcohol and drug abuse, mental health, poor housing, and especially the vision, dental and nutritional difficulties of children, the agency respondent felt that it was impossible to talk about health maintenance among farmworkers in the Imperial Valley.

The county recently opened a small mental health division, with in- and outpatient capability. One of its staff members notified the farmworker organization of the services, and, despite the stigma that many people attach to mental problems, a substantial portion of the new program's clients were farmworkers. The respondent could not determine the caseload proportion of migrant and other farmworker clients either by records or from contacts.

The establishment of the county mental health clinic was undertaken only after pressure was applied by the state government. Withdrawal of other state monies was threatened if this state-required service was not implemented. There have been coordination problems with other agencies since the program was implemented.

Thirty percent of the mental health staff is bilingual, including two of the psychologists, a psychiatric nurse, and a recreational therapist. Ten to fifteen percent of the caseload are children, and forty percent of the caseload is Spanish-speaking.

The heroin problem in this area was indicated to be greater than the heroin problems of New York and Los Angeles because of heroin's ready availability at relatively low cost near the border. In addition, alcoholism is a major problem among the low-income Spanish-speaking population.

Additional Services

The county mental health clinic receives some child abuse referrals, but few from the farmworker community; these were not likely to be from migrants. A problem in establishing better relations with the schools, both to improve child abuse case handling and for general child and minority advocacy, is that schools reportedly don't want to aid in child abuse identification because of the parents' anger when their family problems are exposed. Most of the referred child abuse cases concern non-Hispanic townspeople. There is a need for foster homes for placing Spanish-speaking children; at present there are no such facilities, nor are they being developed. The few non-Hispanic foster homes reportedly would not take Mexican American children. The antipathy of the county government was cited as a major impediment to solutions of the drug problem which contributes significantly to family disintegration and child abuse.

Another EOC program helping in the recruitment effort is Grass Roots, the primary purpose of which is door-to-door assistance for food stamps applications, but outreach workers often discover other family needs that may be unmet. A high percentage of those covered by the Grass Roots program are migrants. In addition, by its activity and visibility, Grass Roots has served to increase public awareness of the migrant population.

The Community Action Program has social workers, as does the local migrant clinic, but the local welfare department only sends workers out in emergencies, and even then does not pay mileage expenses. The health department similarly does not send service workers out to homes, but Child Protective Services does. As many families do not qualify for services under various programs, coordination through outreach is needed.

Services and Needs in Fresno County

Social Services

Few migrants are now found in Fresno County, according to the Fresno County Department of Welfare respondent. With the changeover to mechanized farming, there are few "professional migrants" representative of the migrant population of past years; according to the respondent, migrants now are relatively well-off and usually own their pickup and camper trucks. The resident farmworker population is very large, however, and many families live in the state-run seasonal farm labor camps in the county.

In data collection efforts, the local welfare department has not in the past identified migrants. The planning office within the department has responsibility for complying with new state requirements for county Title XX applications, with recently required needs assessments scheduled to begin in late 1977. Thus, neither the amount of the current welfare services to migrants nor the degree of unmet need were known, but it was reported that as much as 75% of the farmworker population may not be receiving services.

With the possible exception of protective crisis services, the foster care, adoption, and protective services programs which this agency provides were described as not applicable to migrants as they are in the

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county for too brief a time to qualify. However, those still migrating who reside in the county only three to six weeks make up only one-third or less of the farmworker population. Farmworkers also include illegal aliens and those who have settled-out and are living in the camps or grower-owned shanty towns. A recent California State Superior Court decision makes illegal aliens eligible for AFDC, although not for Medi-Cal or food stamps. (Varela v. Swoap, Superior Court of California, Sacramento, Docket #251426) If the department's citizenship test, used for all applicants, reveals a person to be an illegal alien, the U.S. Immigration and Naturalization Service is contacted to see if deportation is in order. If not, services can be received. The basis for the citizenship check is presentation of voter registration papers, said to be easy to obtain fraudulently.

Large family size (five to six members in contrast to three to four for the rest of the welfare population), low education, few skills, limited experience, and poor health were all cited as problems in serving the farmworker population. Health education is a problem as families do not bring their children for needed treatment. Other health hazards especially in the illegal alien population include high rates of venereal disease and tuberculosis. Malnutrition is also a problem, but not significantly more so than in the nonfarmworker population.

The department has no contact with the local Community Action Program, nor with migrant camp owners, and provides no direct outreach or transportation for farmworkers. The department has units in the county hospital, the county health department, and the migrant health clinics that take welfare applications. According to the county social services agency respondent, 90% of the Mexican Americans in the county spoke English, and the department's lack of bilingual staff was not viewed as an obstacle to service.

Child Care

A large farmworker organization with many programs, the Greater California Education Project (GCEP) is located in Fresno County, but none of its day care/child development projects are located in the county. GCEP operates eleven child development centers in counties to the north and south which are funded by the Migrant Manpower and Migrant Head Start programs. Plans are underway, however, to open an additional center in Fresno County.

The only day care in Fresno County specifically for migrant children is provided in the two state-run migrant camps with 125 and 75 families each. The day care centers are operated by the state Office of Child Development. Considered migrants under the state's program definitions, persons living in the camps are often seasonal farmworkers who do not travel but consider the camps their permanent homes for all but the winter months when the camps are closed.

GCEP staff all have farmwork experience and include one supervisor, eight head teachers, and thirteen additional teachers, all of whom have at least twelve units accredited in child development. There are also fifteen teacher's aides, nine community aides, six bus drivers, six custodians, and three secretaries. The 1:8 teaching staff/child ratio is below FIDCR standards. Health, mental health, nutrition, education, parent involvement, and services for the handicapped are all part of the program.

The centers are small, relative to the need at each of the camps; the facilities are old and largely substandard. As many migrant families live in the vicinity of these camps to be near family and friends, the centers in the camps enroll some of the non-camp children, but it is rare if all eligible children in the camps are served, much less those from outside. Migrants stay from the time the camps open in April and May until the end of September, just before the camps close. Although most children stayed for the full duration of the program, 210 migrant children left as their families moved on, so that more children were enrolled (450) during 1976 than there were slots (366). The centers each serve from 25 to 60 children; the average number of children served is 41, increasing to 46 during the peak season.

It is the policy of the child care centers in these camps to serve as many eligible children as possible. None of the funding for the centers comes under the Federal Interagency Day Care Requirements, and, therefore, they do not have to meet staffing ratios. Sometimes the number of staff is too few for the children being served; neither of the centers can meet the demand for care of the eligible two-to-five year olds, much less for the infants.

Camp housing was available for 200 families, but 350 were turned away. Of the 222 children in the camps under six years of age in the camps, 72 were less than a year old. Due to the small facilities and inadequate staff, camp centers are ill-equipped to provide child care to these infants. Other than the proposed GCEP plan to open a center in Fresno County, which, like current GCEP centers, would serve two-to-five year olds, there is no other child care available for migrant children in the county from any source.

The Fresno Economic Opportunity Commission, a Community Action Agency, operates a large network of Head Start projects throughout the county. While some are in towns, it was indicated that even these are not likely to serve migrant children as most migrants stay in very remote areas. It was estimated that of the three thousand eligible children, only about 30, or fewer than 4% of the 700 children served by the EOC program, were migrants. Seasonal farmworkers, who live in cities as well as rural areas, benefit somewhat from these projects. In the Fresno area, most of the program's emphasis is on the urban minority and lower income population groups. It was estimated that about 35% of the program's participants were seasonal farmworkers' children. Seven of the seventeen centers are located in the city of Fresno, but the EOC program has a mobile van to assist in outreach activities for the outlying centers. Three of the centers are open year-round; the other 14 operate only during the school year. In addition, all children in the Head Start program benefit from health care and a complete educational curriculum.

Although operating in school facilities, the Head Start program is not coordinated with Title I Migrant Education which does not include preschool care. GCEP staff was unaware of the nature and operation of the centers in the state-run camps. Improved coordination among these programs would be beneficial to the effective provision of child care for migrant and seasonal farmworkers in Fresno County.

Education

Twenty-six school districts in Fresno County participate in the Title I Migrant Education program, serving approximately 4,500 children identified as migrants. Information was received from nine LEAs representing 2,336 children or just over half of those identified. LEAs not responding tended to be in the smaller, rural districts. Projects reporting ranged in size from the one in the city of Fresno which received $577,577 for 1975-76 and served 1,070 migrant children, to a project that operated only four months of the year serving 25 children and receiving less than $4,000 in 1975-76. Of those reporting, most were in the $200,000 to $400,000 range, despite an average of $101,000 due to the number of smaller projects. Per pupil expenditures varied directly with program size; the largest program spent $474 per pupil, the next $273. None of the four smallest projects reporting indicated per pupil expenditures more than $200; the smallest program spent $159 per pupil; the average was $263. The largest project employed 56 staff members. The average was 13, although the two smallest had only one each.

Of the nine districts responding, only two felt that the MSRTS was an effective method of transmitting educational and health records. The other districts cited errors in information received, delays in receiving printouts, and inadequate information on the forms.

All districts indicated that health diagnosis and treatment were provided; all but one provided immunizations. Only one district indicated that a social worker was available to migrant students, while four mentioned psychological counseling. Only two districts provided accident insurance. Only three of the larger programs had breakfast programs, and only the largest offered a career vocational counseling program for secondary level students. This program, however, also indicated that it does not run any of its components exclusively for migrant children, although 200 of the 1,000 migrant children in the district were said to benefit from it. Only one indicated that outreach and recruitment were parts of its program functions, supported by the county rather than by the Migrant Education program. Four of the larger programs operate summer school sessions for migrant children and serve nearly 700 students. Only one of the districts reported that preschool child care was part of its program, and that district reported that only three of its 260 children benefited.

Although responses showed that in most of the districts 90% of the children in the Title I Migrant program were Mexican American, three of the districts indicated that their programs did not contain bilingual/bicultural components; two of those districts had no program exclusively for migrant children. Only the district with the largest program indicated that some schools within its boundaries had enough migrant children to qualify for a Title I Migrant program but did not choose to participate.

It was estimated that one underage child per migrant family stays out of school to work in the fields, resulting in a significant child labor problem in the valley. Unfortunately, the solution requires dealing with the family's finances and internal organization.

Health

The Fresno County Health Department and United Health Centers of San Joaquin Valley, the migrant health clinic, are two main providers of health care for migrant workers and their children in Fresno County. The central Valley Regional Center also provides services for children.

The health department, in a decentralization process, operates two pilot satellite centers; their effectiveness is being monitored to determine whether to open six or eight more satellite centers in the county. The department also sponsors three temporary clinics, one of which is in a facility shared with the local migrant health clinic satellite. The two county pilot satellites serve few migrants, although migrants are served by the periodic health clinics operated by the county department. The county also has been sponsoring Health Roundup screenings for all school children. Held in the schools during evening hours with parents present, these clinics reach a large number of migrant and other farmworker families.

Satellite clinics are felt to be the best way to address the migrants' needs, but there have been problems in licensing new satellites due to state health facility licensing requirements which assume health facilities are in buildings designed for the purpose. Problems in having later evening hours so the satellites could be more accessible, and increased staffing during peak seasons, not done at present, were cited. The county plan for the satellites specifies that the entire medical staff of a facility move to the rural community in which it is to be located, so that they can provide a true community-based service.

There is a dearth of Spanish-speaking physicians--only two who are Puerto Rican, whose services are used whenever possible in the clinics. They receive higher salaries for their language facility, and are received enthusiastically by the clients. Receptionist positions in the department are now staffed by bilingual persons only, because many clients, while able to use English, prefer to talk with a Spanish-speaking person. A number of other staff in the department are taking a new, local community college course in Spanish for health professionals.

The forms the department now uses for registering new patients request information on the home: specifically whether children have beds of their own and whether refrigeration is available. A staff person checks responses to these questions, and, if either answer is negative, a public health nurse counsels the parent on ways of making beds for infants and children (to avoid their being crushed while sleeping in the same bed with a larger person) and about food preservation and food poisoning dangers.

Communicable diseases and worm infestation were among the worst health problems of migrant children. Pesticides were also cited as severe health hazards for all farmworkers and their families. A portion of the department's VD prevention program involves sending a mobile unit to the local camp; there are very high rates of VD incidence because organized prostitution rings visit the camps every weekend in vans. Other than the VD program, and the Health Roundup clinics, which suffer from poor transportation arrangements, the department has no general health programs which clearly benefit the migrant farmworker population.

The needs of the farmworker population, according to the health department respondent, are at present 90% unmet. The department estimated that the migrant farmworker population was 8,500 persons, a figure considerably higher than the "few" referred to by the county welfare department.

The health department does not, at present, offer the WIC program, but does have an application pending with the state. There are two WIC programs in the area, run by the EOC and the migrant health clinics, serving the 1,700 people that the health department would otherwise serve. It was indicated that having these groups provide the service rather than the department, "forces people out of the mainstream into an agency that may not be high quality." As this comment exemplifies, interagency coordination was poor in Fresno County although the EOC, health department, and migrant clinics have representatives on each others' boards of directors.

Another provider of health care to migrant farmworker families is the United Health Centers of San Joaquin Valley (UHC), which has two clinics in the southern part of Fresno County and constitutes the largest migrant health clinic program in California. Its director is chairman of the California Rural Health Network, an organization representing five migrant health clinics in the state. UHC plans to expand its catchment area and open two more clinics in the western part of the county. It has obtained 90% Hill-Burton funding for construction of two new clinic facilities to replace the present clinics at a cost of $4 million. This is the first time Hill-Burton funds, usually awarded for hospital construction, have been made available for community clinics. UHC's annual budget is $1.6 million. Because of the federal migrant health program cutbacks, UHC suffered a 20% funding cut in 1976 while obligations such as malpractice insurance premiums have risen--from $47,000 to $105,000 in one year. The clinic also carries a $300,000 debt for unpaid services.

However, an increase in patient load has reportedly been accommodated through savings generated by eliminating the X-ray and outreach departments, and reducing staff throughout the organization. Unfortunately, by eliminating outreach, the clinic is providing less effective care through lack of follow-up, failure to detect disease early, and inability to monitor changing community health and environmental needs.

The clinic has seven physicians, including a surgeon; four dentists; and three nurse practitioners. An obstetrician is available three days a week. There is a small laboratory, although some work is sent to the county lab.

A number of growers use the clinic, and several non-agricultural employers have signed contracts for their employees' health care. In 1975-76, migrant farmworkers comprised only 34% of the patient load, out of a total of 15,000 patient visits.

The Head Start program sometimes uses the migrant health clinics for care of eligible children, but usually depends on its own resources. With a dental program, a small clinic staff of three physicians in the Fresno central EOC office (which also houses a WIC program distribution center), and an outreach staff comprised of five social workers, five regular nurses, and five nurse's aides, there is thorough attention to the needs of the 700 children in the program. Nurses carry out preliminary investigations of the health needs of children new to the program and send the mobile medical/diagnostic team by van to perform physical examinations and meet the families. Any necessary follow-up is then arranged. There are also funds available for hospitalization. In 1975-76, almost all the children received physical examinations; speech, vision and hearing testing; dental care; and immunizations. Home contacts and parent conferences for each child are planned two to three times during the year.

Farmworker health problems cited include slow gas leaks in the camps, that over time trigger reactions in the residents that may be too subtle to be diagnosed correctly but may also cause seizures, and the use of pesticides near camps. A San Joaquin Valley fever, caused by a fungus that develops in the body from chemicals unique to the soil in the region, can be incurable if not detected. The clinic has an agreement with a major university medical center for operations for cleft palates, a common occurrence in the valley. General infections such as otitis media; eye, scalp, skin, and foot problems; poor nutrition; and exposure are also common.

The central Valley Regional Center (VRC) is part of a network providing services under state Health Department funds. VRC provides both direct care and consultative services on any case brought to it concerning crippled or otherwise handicapped children. VRC has provided administrative in-service training for the local migrant health clinic. Although services are not targeted at any specific population group other than children, VRC has a significant part in improving conditions among migrants and the rural poor.

While VRC serves a large number of Spanish-speaking persons, the respondent indicated that disabilities, such as minor neural disorders, were largely left untreated under the conditions of migrant poverty, possibly causing lasting emotional and behavioral consequences.

One of the ways an organization like VRC can be most useful is by planning and coordinating all treatment for a child who needs special care, including education, physiotherapy, counseling, and so forth. While there is no residental program at the Center, there is a day care facility for exceptional children, 40% of whom are Spanish-speaking children, some of whom are migrants. There is no outreach to recruit for this program, but transportation is provided as needed.

Migrants have an especially difficult time with chronic ailments. In such cases, the Center can only train the family and provide some liaison to agencies where the family is going, when destinations are known. The need for improved records transmission was cited. Often, migrants are preparing to leave the area by the time they are referred to VRC; it takes almost the full season for their needs to be identified and for referrals to be made.

Additional Services

The Fresno County Economic Opportunity Commission, a Community Action Agency, serves many migrants through the Head Start and Rural Migrant Nutrition programs. Mexican Americans comprise 70% of those served; 20% are Black; 7% are White; one person is Indian, and the rest are Asian. The children are served in seventeen centers, only one or two of which are in the regions where migrants are likely to live.

The EOC Rural Migrant Nutrition program is equipped with a mobile van which contains equipment for showing videotapes. The bilingual tape library has descriptions of all local service programs, as well as nutrition education tapes. The dental program at California State University, Fresno, provides a tape on dental hygiene and a staff member who, along with three or four nutrition aides and the program director, visits 172 of the county's 240 camps by preseason arrangements with the owners. In 1975-76, the first year of the program, many families were hesitant to participate, and some stayed away when they first saw the van, thinking it was from the INS; but the next year, they were waiting for the staff to arrive.

The staff members go into the homes to work side-by-side with the mothers to help improve the families' diets, demonstrating such techniques as canning and food preservation. Due to its mobility and ongoing contact, the nutrition program has thorough knowledge of migrant conditions in the camps and receives many calls about three-year old children being left to care for one-year olds. One of the main concerns of the program is in raising the parents' level of commitment toward improving the lot of their children, and to develop parents' awareness of their ability to seek out resources. While dental and health education are keys to proper parenting, the family approach, involving all family members, includes stimulation fo the children's interest, so that nutritional gains are reinforced for succeeding generations.

Nutrition staff meet monthly with the mothers of children in the EOC Head Start program. Besides seeking community involvement in determining that nutrition information is consistent with affordable prices and cultural preferences, the staff advises mothers on availability of welfare programs, such as the following: WIC, the community coalition emergency food assistance, hypertension screening, and the energy voucher program whereby people with incomes below the poverty level can obtain vouchers for up to $50 toward payment of gas and electricity bills. Mothers are also advised of the location of satellite Food Stamp offices, migrant and county health clinics, and the county rehabilitation department. The EOC and farmworker organization could benefit from this example and work more closely together.

The Centro de Familia in Fresno, with offices directly across the street from the county welfare department, functions primarily to assist Spanish-speaking persons applying for public assistance. It is also a contributing organization to the local coalition group that provides information, referral and follow-up, emergency food and shelter, and other short-term assistance unavailable through the welfare department. Centro is developing a network of Food Stamp outreach contacts throughout the county, with at least one person in each elementary school district. All interested parties, including grocery store owners, school officials, home-school aides, etc., can be contacts to discover information concerning families in need of Food Stamps so the Centro can help them.

Centro de Familia is funded through county revenue sharing funds. The staff has one social worker with a Master of Social Work degree, a director, and students (undergraduate and graduate) from local colleges who provide counseling and assistance services under work-study programs through which they receive academic credit.

Other Centro operations include assistance with naturalization, working to stop the welfare department from turning illegal aliens over to the INS, and working to improve the quality of care provided in rural health centers, both county-run and migrant.

Farmworker Organizations

Imperial County

Campesinos Unidos, Inc. (CUI), is the primary farmworker organization operating in the Imperial Valley of southern California. In addition to its child development and day care programs, CUI provides manpower training and job development under the DOL Migrant Manpower program and also furnishes Food Stamp program applications, emergency food supplies, and vouchers under the emergency provisions of the Food Stamps program. As CUI requires documentation, few problems were noted in providing these services to illegal aliens. CUI also serves as a farmworker community focal point, hosting community meetings. Coordination with other local service agencies, such as the local migrant health clinic, has been more formal than functional, although improved relations are expected due to staff and procedural changes at the clinic. Liaisons with other agencies, particularly public welfare and health, are similarly maintained on a formal level for purposes of information flow. There are few community meetings at which local farmworker programs are represented other than CUI's monthly meetings in each community it serves in the Imperial Valley. Sharing occurs largely through individual decisions, such as Campesinos' standing offer to let other organizations use its buses on the weekends. Transportation is a real problem, because no program besides the CUI Child Development program provides it.

Referrals occur as needed, but there is no council of all agencies serving the farmworker which could evolve a comprehensive formula for coordination to assure maximum utilization of available resources.

Fresno County

The Greater California Education Project (GCEP), a farmworker advocacy organization, specializes in child development and manpower training/job development programs. Founded during the 1960's with funds from the Office of Economic Opportunity and other sources, GCEP has been involved in educational training and management development activities. It is among the largest of the ten to twenty organizations operating in the San Joaquin Valley which provide supportive services to migrants and other farmworkers.

The GCEP central staff includes the director of early childhood education, a handicapped services specialist, a health/nutrition specialist, and an education coordinator. There are no registered nurses on the staff but health services are provided through contacts with local providers. In referrals, the health specialist goes to the day care center, takes the child to the doctor or clinic to set up the initial appointment, and then turns the case over to the day care center's community aide to schedule future appointments. The program did not use and was unaware of providers for the EPSDT program or the WIC program. All centers use the Santa Clara Testing and Evaluation Package with a curriculum developed by the Southwest Educational Laboratory, as required by the Migrant Head Start program. There is a parent advisory board for each center and a nine member board, which includes three migrants, for the whole program.

The GCEP day care program has no fees, but does screen for local residency and income eligibility. In the past, GCEP has had difficulties in starting centers in communities that did not previously have programs for migrant children. It has been necessary to overcome local reluctance in each case by communication with the communities involved. GCEP representatives work with community groups to increase acceptance. GCEP has no organized way of informing the general public about migrant child welfare problems, however.

State Service Provider Agencies

Social Services

The Division of Social Services, in the California Department of Health, does not identify migrants in its data. The state-supported migrant day care program in the state-run labor camps does not use Title XX funds, and there are no other direct state welfare department programs for migrants. Although there is a Seasonal Agricultural Worker Advisory Board with 15 members (number of migrants unknown), no direct programming, training, or contracts have been undertaken by the department for migrant families. The Department supported the migrant day care program during the 1970-75 period, using funds under Title 4-A of the Social Security Act. With the changeover to Title XX, migrant day care was continued another year under Title XX, on a separate contract arrangement rather than as a line item, and funded separately thereafter. The program now operates at a level of $1.5 million.

About $30 million of California's Title XX money goes into protective services. The state level Protective Services office had little information concerning services to migrants. The staff of four persons spent almost all of their time answering inquiries from local offices and the public, leaving no time for travel to work with the counties in implementing effective protective services programs.

In California, each county must designate one or more protective services caseworkers who may also have other responsibilities. In many of the smaller counties the director assumes this task along with many other duties. Respondents commented that a Title XX set-aside for migrant protective services to fund bilingual workers who would serve only migrants is needed. Some anecdotal information obtained concerning actual services to migrants (emphasized as not reflecting the policy of the unit) indicated that where there is identified child abuse in a migrant family, the "treatment" might consist of their being asked to leave the county. Another respondent gave conflicting statements and spoke of the well-intentioned social workers who handle protective services cases, saying that such discriminatory and detrimental practices do not occur.

Prior to 1971, all dependent children were cared for under the probation departments in their counties. In 1971, the state reformed the system, allowing the counties to choose probation department care or care by social service departments. Many did not switch, thus making uniform administration of protective services procedures difficult. The California central registry for child abuse and neglect information, for example, is in the state Department of Justice. Some counties, still using probation departments, keep children needing emergency shelter protective care in juvenile detention centers. The state office has recently declared that, without a judicial ruling, children cannot be in protective care for longer than 14 days. The federal limit is 30 days, but California tightened this limit as a general money-saving and efficiency measure as well as due to the counties' use of detention facilities for protective services.

There was little direct knowledge of how counties with substantial farmworker populations serve migrants. Protective services caseworkers in theory are outreach workers and provide transportation as needed, since they interview families in the home. However, it is likely that restraints keeping other welfare agency staff from serving migrant camps affect protective service workers as well. If a family is receiving protective services, the case records are forwarded at local discretion when they move. Some counties forward the records, and some do not.

Although no reports of migrant child abuse or neglect had been received in 1975-76, if cases were received and an investigation proceeded, the family would receive help, including education in parenting. In severe cases, incarceration might result. Despite the theoretical availability of protectice services, a family might be found ineligible for services, on several grounds: "inappropriate referral," presumably meaning the caseworker decided that another agency should be given the responsibility for looking into the case; "out-of-county resident," likely with frequently-moving families in rural areas; or "problem resolved," which can mean that the episode was not repeated and the caseworker feels it would not recur, or that the family took care of the matter privately; it can also mean that the family just moved on.

Child Care

The California Department of Education Office of Child Development administers all state-provided day care. A section of this office is responsible for the migrant day care centers in the state-run labor camps. Because much of the day care is state-funded, (and credited toward the state's 25% match for receiving Title XX funds), federal day care standards do not apply. Title I Migrant funds are used for the child care programs run in the camps, augmented by funds from state program AB-99, a rural program funding source which provides day care for some migrant children living near the camps, as well as for one hundred children in the Imperial Valley, as reported above.

Funding for the state migrant camp day care centers includes $1.1 million from Title XX funds, $457,000 from the Economic Development Department, and $456,000 from the Title I Migrant Education program, totalling $2 million for 2,500 day care center slots. Twenty-five of the forty-seven sites supported by the migrant day care program are in the state-run camps. The others are run under contracts to public agencies, such as local education offices; to private agencies, such as local Hispanic advocacy groups; and directly by the state, such as in San Diego which recently had a large influx of migrant workers.

Participation in state-sponsored programs is determined by the following Title I Migrant Education eligibility criteria: In order for a parent to work in agriculture, a child has changed school districts within the past year; or, a child's family has been settled-out from agricultural work for up to five years. Title XX income criteria are applied to determine need.

Several problems are inherent in California's program. Almost none of the care is for infants--only five percent of the children served are under two years old. The camp-based day care centers must close when the camps close, even though many families are year-round residents. The centers are overcrowded, with materials in short supply. The camps are old, many built near garbage dumps and other undesirable locations. The program does not pay large enough salaries to attract qualified teachers, relying on available staffing resources--parents and part-time aides. The state does not coordinate the migrant day care and migrant Head Start programs.

Health care has been a main problem. Title I Migrant permits only basic preventive care, such as physical examinations and immunizations; it does not cover comprehensive treatment. Wherever possible, county health nurses give extra care. Attempts were made for the 1976-77 school season to arrange for health care through migrant health clinics before seeking other providers.

Education

In response to a 1974 mandate from the State Legislature, the California Department of Education prepared a "Master Plan for Migrant Education," outlining utilization and coordination strategies for the several programs that benefit migrant children in the state. While the state supplied monies only to develop the plan and maintain a small contingency fund, there is available federal funding for programs. However, programs such as Title I Migrant and Title VII Bilingual Education do not have objectives sufficiently similar to coordinate programmatically; any coordination that does exist is oriented toward program monitoring and fiscal control. According to the respondent in the Office of Compensatory Education administering the Title I regular and Title I Migrant programs, there is no coordination between that office and the state Social Services Department, farmworker organizations, or Migrant Head Start programs. Communication and coordination between agenices is exacerbated by the political effects of a State Education Superintendent's elected rather than professional status.

The Title I Migrant program is administered through eight regional offices which submit annual applications as LEAs, with one of the districts in each region acting as sponsor. The state then allocates the money to the region as a whole. This gives the regional directors flexibility in working with the communities and schools to meet local needs; however, it also places the regional directors in an ambiguous position with regard to autonomy and fiscal control. For example, one director was eager to use Title I Migrant funds for day care but was not certain if the state office would approve the expenditure. There is, in fact, little expenditure of Title I Migrant funds statewide for preschool care, despite an explicit policy of the Department of Education which places a high priority on early elementary and kindergarten programs.

The size and features of the California program make it a showcase for many ideas and approaches within the Title I Migrant framework. Innovations include special programs and modifications of regulations to meet specific needs. In all but one district, the Parent Advisory Council (required by California law even prior to the inception of Title I) participates in the hiring of staff for the migrant program. California has just signed an agreement with the statewide network of migrant health clinics for Title I Migrant programs to give first-option contracts to the migrant health clinics in their areas before going to other providers. There is also an extended day program during the summer months which operates in the afternoons following the regular program so that children will not be left unattended while their parents are working.

There are Medi-Corps and Mini-Corps programs to train former migrants in service to migrants (see Chapter II of Part Five of this report for further information on the Mini-Corps program), and statewide training programs for local project staff members which are quite popular. One training session was attended by 380 of the 400 community aides in the state.

Finally, although the program is targeted at the K-3 grade levels, experimental programs at the secondary level in seven LEAs provide career counseling and vocational training to 1,700 of the 17,000 program participants in grades 9-12.

Funded at $18.5 million and serving 33,900 children, the California supported program is second only to the Texas program in size. Even so, the state education office estimates that 50 school districts, serving 10,000 migrant children, do not participate, and only two of the eight regional LEAs currently are operating outreach and recruitment programs.

Health

The California Department of Health operates a Rural Health Section in its Preventive Medical Service Branch to provide resources for the improvement of health care in rural areas. Originally, the Section's work was targeted exclusively at health care for farmworkers, but since 1975, the emphasis has broadened as more and more non-agricultural areas of the state have sought assistance.

The resources provided are of two kinds. First, the Section provides technical assistance in the establishment and operation of clinics in farming communities. Examples are the provision of grants and loans for development of local services; and administering the California Health Service Corps--all under a $4.5 million two-year program initiated January 1, 1977. Second, the Rural Health Section monitors the expenditure of state Maternal and Child Health program monies in rural parts of the state. The Section has a reputation as activist and Hispanic-oriented, with bilingual staff and a willingness to go far beyond traditional concepts of technical assistance in working toward community control while "building bridges" between new groups and the established power structures in rural communities. However, priorities are with community facilities rather than with direct service to migrant farmworkers. While the Section does not have data on the number of migrants served, the director was instrumental in founding the Texas-based National Migrant Health Referral System; however, the Section has never reviewed or utilized the Migrant Student Record Transfer System, which contains health information, nor worked with the Title I Migrant program at the state level.

Migrant health clinics remain the basis for the organization of rural health care in California. The $3.4 million budget for the entire state hardly meets the need, while recent budget cuts have severely reduced transportation and outreach capabilities.

Additional Services

The Office of Migrant Services of the state Health and Welfare Agency operates a network of 25 migrant camps, in operation since 1965. Originally funded by the federal Office of Economic Opportunity, and later by the DOL manpower program, the camps have been supported since 1976 by state funds. A number of types of housing are used, including some special prefabricated units called "paper houses," but most are typical of military barracks. Respondents in Fresno County characterized the camps in that area as "concentration camps." The operation of these camps and the child care centers therein are discussed in greater detail in the section above on Child Care.

Recently implemented, the other main function of this office is to serve as the primary coordinator of all state programs impacting on migrants. By Executive Order of the Governor creating the position, a Rural and Migrant Affairs Coordinator was appointed in late 1976. With $250 million at his disposal, the coordinator foresees no problems in the capability of his office to seek and receive cooperation from all agencies involved, including the Legislature. To implement coordination, a plan has been developed to bring together, as an advisory board, the top and middle management officials who run the programs, interfacing that group with a second advisory panel of representatives from the state provider agencies. If coordination develops as planned, accurate program information will be available to all agencies, programs can be more effectively targeted to needs, and program officials will be able to guide user representatives in the most efficient use of available human services resources.

CHAPTER II

COLORADO: WELD COUNTY

Migrant farmworkers arrive in Colorado from Texas and New Mexico in advance of the farmwork season, which generally begins in mid-May. The largest single group of migrants is Mexican American, but there are also substantial numbers of Navajo and Kickapoo Indians. Migrants come to the four agricultural regions of the state--the northeast, the Arkansas Valley, the San Luis Valley, and the western slope--and work crops of sugar beets, cucumbers, tomatoes, and potatoes. Some migrants stay until long after frost in the fall and dig carrots or potatoes until mid-November.

The peak work period is from May to September, and summer migrant child care and school programs generally run from May to mid-August with school programs resuming in September. Estimates derived from MSRTS records indicate that approximately 8,800 children migrate to Colorado with their parents each year.

Weld County, in the northeast area, has the highest population of migrants of all Colorado counties. The land there is the flat, western edge of the plains, and many different crops are grown and tended by migrant laborers. The dust storms, such as those which swept eastern Kansas and western Colorado in the spring of 1977, reduce farm production and thus the demand for farm labor. The scarcity of housing for the workers continues to be a critical problem. Many migrant families live in cars, along roadsides, or in town parks. Most of these people do not have access to water for bathing or sanitation. They are often inadequately protected from the elements. In the San Luis Valley, families who stay to dig potatoes withstand below freezing temperatures in dirt-floored houses without heat or electricity.

Although Colorado agencies serving migrants have maximized the use of available resources through coordination, the housing needs of migrants will not be met without additional funding and a massive effort.

Weld County migrants are served by a responsive farmworker organization, and have access to child care, education programs, and social services. The following Weld County organizations and agencies were contacted: Colorado Migrant Education Council, Title I Migrant Education Program, Bilingual/bicultural Program, Colorado Migrant Council Head Start/day care, Department of Social Services, Plan de Salud del Valle, Colorado Rural Legal Service, and the Weld Information and Referral Service.

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Services and Needs in Weld County

Social Services

The Weld County Department of Social Services (DSS) provides a variety of services. The provision of services is contingent upon a funding procedure which gives counties the major responsibility for the development of program priorities.

As in other Colorado counties, Weld County residents contribute 20% as their share of matching funds for Title XX services provided in the county. Based on the county option to modify the state plan to conform to local conditions, the Weld County plan differs from the state plan in two respects. One modification lowers the median income from that of the state to that of Weld County, which is $13,000. As a result, fewer people are eligible for services. The other change allows two-parent families to obtain day care if they work a combined total of sixty hours or more per week. In the rest of the state, only one-parent families or families in which the second parent is incapacitated or unable to work are eligible for day care. Thus, in Weld County migrant families may be eligible for day care if they are on public assistance and prove an intent to reside (under which those who are settling-out might qualify) or if they are income eligible. Day care slots can be purchased by DSS for children of these families in existing centers. Twenty-three migrant children were referred to the La Salle Parent Child Center when the Colorado Migrant Council, the migrant day care provider, closed its centers at the end of summer. The county has an annual day care budget of $202,000, and thus far the demand has never exceeded their budget. The Weld County DDS also contracted with the Colorado Migrant Council for day care slots for approximately 30 children in 1976.

The only other category of services in which the number of migrant children served was known is that of child abuse and neglect. The protective services director knew of two cases involving migrants. There are no eligibility requirements to be met for protective services, but the funding level is so low that the agency can only respond to serious cases. It is not possible for DSS to investigate and provide follow-up in cases of situational neglect.

There are separate funds for the county medically indigent. Although the client must be a Weld County resident, the period of residency is not specified. These funds are made available to parents who are unemployed and have dependent children. However, all other sources must be exhausted before these funds may be used. According to the director, the funds usually run out in the middle of the year, or halfway through the migrant season.

No former migrants are on the social services staff, but there are several bilingual social workers and assistance payments workers. Social services are coordinated with the Weld County Information and

Referral Services (WIRS), a nonprofit community organization that provides information and referral.

WIRS receives money only from the United Way, and operates with one full-time and one part-time paid staff members and several volunteers. The director does not apply for funding from other sources, believing that added eligibility and reporting requirements would impose unacceptable constraints on program operations. WIRS serves all people in the county, but began to identify migrants separately a few years ago. An average of 500 migrants are served each season by WIRS. The director is available at all hours on an emergency basis. Routine services consist of referrals to all agencies and organizations for all the services a family needs, directions on how to locate the agencies, and often a personal phone call to the agency on the person's behalf.

Critical problems faced by farmworkers are the shortage of housing and the lack of jobs at the beginning of the season. Many people are referred to WIRS from the Colorado Migrant Council because they are not eligible for CMC services when less than 51% of their income is derived from farmwork. Often migrants do not do farmwork at their home base in Texas, and this makes them ineligible for the CETA-funded services of the Migrant Council.

Child Care

Migrant child day care is provided statewide by the Colorado Migrant Council (CMC) through funding it secures from Head Start and CETA. The facilities used are public schools where Title I Migrant summer programs are operated. The Migrant Council also contracts with Title I for bus transportation for the day care children. The Weld County CMC is responsible for the provision of migrant day care in all of northeastern Colorado. In 1976, a total of 231 migrant children, aged two weeks to five years, were served in Weld County centers in Brighton and Greeley. This reportedly provided sufficient coverage during the major portion of the summer, although there were children still in need of service when the centers closed in the fall. All centers close in August for the two-week cleaning of the public schools.

There are former migrants on the day care staffs, although no exact count was made. The Brighton Center was operated through the local Chicano community center with some of their staff. The center in Greeley utilized the services of college students majoring in bilingual/bicultural education. Curriculum is individualized according to children's needs.

Outreach to families was a coordinated effort by the Head Start day care program and Title I Migrant Education. There were some coordination problems between the Head Start day care programs and Title I Migrant programs at individual schools. The local CMC director submitted questionnaires to both staffs to elicit comments on problems so they could be resolved by the following year. All day care staff attended four days of training provided by the CMC state office.

Problems mentioned at the local level included difficulties in coordination with Title I Migrant programs and early closings of day care programs. It was also stated that there are problems in licensing facilities for very young children. The size and kind of equipment required, as well as the physical setting, often present difficulties in serving toddlers. The licensing process is slow, but it was felt that if present licensing regulations were enforced, most public schools would be unable to meet them.

A Parent-Child center in Greeley serves migrant children after the CMC centers close each year. This center is not funded under the OCD Parent-Child Centers program, but is designed around similar goals of extensive parental involvement and training in caring for children from infancy through age three.

Education

Weld County Title I Migrant Education programs are operated through the Weld Board of Cooperative Educational Services, which includes seven school districts. A total of 900 students were served in Title I Migrant programs in Weld County in 1975-76, approximately 100 less than the previous year.

Those students who remain for all or part of the regular school year are provided with direct educational help through individualized instruction. Four hundred students are enrolled in the eight-week summer program in two schools. Although the summer program was cut back from three centers to two in 1976, the program accommodated all eligible children.

The summer program is more comprehensive than the school year program, and includes cultural and social experiences as well as nutritional and medical services concurrent with academic programs. Hours are usually from 8:00 a.m. to 3:30 or 4:00 p.m. Children's health services are provided by nurses in the schools, and the migrant clinics at Gill and Ft. Lupton are used as necessary.

All six of the teachers at one of the summer sites are bilingual; three out of six who teach at the other site are bilingual. Two family-contact people at each site work to ensure that parents are invited to school functions.

Title I Migrant has enlisted community support and participation in its summer programs. The program has access to swimming pools in Greeley and Ft. Lupton. In Kersey, students benefitted from the cooperative program efforts of the Soil Conservation Agency, the Department of Wildlife, local farmers, and Title I Migrant Education, which provided an environmental study curriculum. A course to investigate a site along a river was developed with materials provided by the Department of Wildlife.

A summer migrant olympics was held at the University of Northern Colorado which donated its facilities as well as personnel and equipment for activities in track, field, and swimming. Children from seven schools participated. Local merchants donated soft drinks and snacks, and state television news teams covered the events. In 1975, the migrant olympics competition was statewide, but in 1976, due to funding cuts, competition was on a regional basis. The University of Colorado at Boulder also hosted a children's day for migrant students, organized by the United Mexican American Students.

Title I Migrant maintains a close relationship with CMC. Day care centers and Title I Migrant programs are often housed in the same facilities, with transportation coordinated for the two programs. Title I Migrant works very closely with the bilingual/bicultural education program which also serves migrant children. In those schools in which migrant students are in the bilingual/bicultural programs, Title I Migrant supplies teachers as needed for remedial work.

There were a number of problems reported by staff of the Title I Migrant program. The Migrant Student Record Transfer System has not proved very useful to teachers in Weld County. Teachers enroll children and enter academic information on the MSRTS, but often when children return the following year, no new information has been entered on the children's records. Health records provide more information, but in many cases are inadequate. Another problem is the shortage of bilingual teachers. The recent Colorado law that schools must provide bilingual teachers when twenty or more students are monolingual in a language other than English has created a great demand for bilingual teachers.

The bilingual/bicultural education program presently operates in six elementary schools in Greeley. Four schools offer the program in grades kindergarten through three, and two schools provide it through second grade. The program has a 24% minority enrollment composed of migrants, mainstream Mexican Americans, and resident aliens. Of these, 103 students are migrants, and about 50% of those are settled-out. Upon entering the program, children are assessed for language dominance and language proficiency. The regular curriculum is used for all content areas except for Spanish reading, English as a Second Language, and Spanish as a Second Language. The program uses an integrated model in which the students are in the same classroom for all of the content areas and are taught the concepts in English and Spanish. Students are separated for classes in English as a Second Language, Spanish reading, and Spanish as a Second Language. Some of the materials utilized are published in the United States, and some are from Mexico.

The bilingual/bicultural program receives no federal funds. The school district is building it into its regular programs. Throughout the state there are 44 such programs which now serve about half of the migrant children. Some of those projects may be receiving federal bilingual/bicultural education funds.

There is one outreach worker in the Weld County schools. The parent group is very active. The bilingual/bicultural program is coordinated with special education, CMC, and migrant health programs during the summer.

The director of the bilingual/bicultural program has worked with migrants during the past ten years and suggested that CMC work to develop more long-range goals, such as teaching migrants the skills to become fully integrated into their communities.

Health

Migrants in Weld County are served primarily at the two clinics in the county--the Eastside Clinic in Gill and the Plan de Salud del Valle in Ft. Lupton. Services for well children and family planning are also available at the Weld County Health Department. The exact numbers of migrants served in Weld County are difficult to determine because the Plan de Salud del Valle at Ft. Lupton serves all low-income people in southern Weld County and in southern Adams County as well. The clinics derive partial funding from the Migrant Health Act.

The clinics at Gill and Ft. Lupton have been in operation for six years and provide medical and dental care. The clinics handle acute problems and some preventive care for children. Cases which do not require medical attention are sometimes referred to the Weld County Health Department which provides only preventive care, and offers family planning, prenatal care, well-baby care, and testing for venereal disease and tuberculosis.

The preventive services offered by the clinics include family planning and prenatal care. The administrator at Ft. Lupton plans to add a WIC program to the clinic's preventive services. Presently, a nutritionist provides education programs at Ft. Lupton twice a week in the summer and at Gill on a regular basis.

Acute care cases are either handled by the clinic during regular hours or are referred to specialists during the night clinics. Patients are also referred to outside specialists when necessary. The staff reported that the most common health problems among migrant children were ear infections and dental problems. Two cases of tuberculosis have been reported.

Night clinics are held regularly, and specialists are available for consultation. The clinic employs two dentists full-time, and makes referrals for complicated cases. During the summer of 1976, the dentists examined about 80 to 100 children. The dentists expressed frustration at often being unable to complete dental work before a family moves on.

Most migrants who need to be hospitalized are served at nearby Brighton Community Hospital. The Ft. Lupton clinic contracts for services with the hospital and pays all fees at a set rate per diem.

Those patients seen at the Gill clinic must first be seen at Ft. Lupton before being referred for hospitalization. This program is operated as a Migrant Hospital Demonstration project through funds received since 1973 from the Migrant Health program, through the federal Bureau of Health Insurance. The funds have been reduced so that now the program can handle only a fixed number of patients. Other in-patient referrals and all maternity cases are sent to Colorado General Hospital, and the Ft. Lupton clinic pays the first fifty dollars in charges. The Brighton Community Hospital plans to have an obstetrician and will then be able to accept maternity cases.

Emergency care is provided at the Brighton Hospital, and the Ft. Lupton clinic has a trauma room in which patients can be stabilized before being transported to the hospital.

There are about 35 full-time employees on the staff of the Ft. Lupton clinic. The personnel includes two doctors (although the budget allows for three), a pediatrician and a podiatrist as consultants, a child health associate, three nurse practitioners who specialize in adult health, five full-time outreach workers, two full-time dentists, as well as one full-time administrator. Twenty-three of the staff members, including the administrator, are bilingual. All of the outreach workers are bilingual/bicultural, most are former migrants, and at least one outreach worker is available 24 hours a day. They accompany patients to Colorado General Hospital, facilitate migrants' access to services, provide transportation when necessary, and in general assist migrants who need help.

During 1975 and 1976, the clinics participated in the Austin-based National Migrant Referral Project in an effort to provide continuity of health care to migrants. The system records history, treatment, and medication, and indicates the approximate time when the patient will arrive. If the patient can supply the name of a specific doctor or clinic, records will be sent to that person or facility. Clinic personnel then watch for the arrival of the patient and outreach workers may be sent to locate the family. The Ft. Lupton administrator believes the referral system works very effectively for those patients who need follow-up or continuing care.

Migrant involvement on the board of the Ft. Lupton clinic has been problematical. At least 51% of the membership of the policy-making board must consist of migrants, as required by the Migrant Health Act. This requirement was interpreted in various ways, and at first the Ft. Lupton clinic operated with two boards--a grantee board and a policy board. The clinic has recently received approval for a single board on which mobile migrants will be represented by settled-out migrants or other designated migrant representatives.

The clinic maintains coordination with Title I Migrant programs, the Colorado Migrant Council, and the Weld County Health Department. Outreach workers from each program explain all of the available services.

The difficulty of securing adequate funding is seen as a major problem by the administrator. Funds for the Migrant Hospital Demonstration Program (MHDP) have been reduced. MHDP funds are used to pay for hospital fees at Brighton Hospital. There is also discussion as to whether Colorado state monies should pay for migrants at Colorado General Hospital.

The administrator also indicated that an outreach health center to serve both migrant and rural people in southern Weld County is greatly needed. He suggests that such a center be staffed by mid-level practitioners whose services would be supplemented by staff at the clinics. There is no money for such an outreach center at the present time. The administrator applied for funds from Health for Underserved Rural Areas for an outreach project to be located in Plattville. The project was not funded, but the community was receptive and provided the facilities. The Ft. Lupton clinic provides a nurse practitioner for Plattville three afternoons a week.

Although adequate funding has been a major handicap to service delivery to migrants, the administrator of the Ft. Lupton clinic has demonstrated his commitment to health care for migrants by actively seeking additional funding and by ensuring that comprehensive services are accessible to migrants.

Additional Services

Legal services for migrants are provided at no cost by a designated lawyer within the Colorado Rural Legal Service. Funds for the special lawyer and three summer interns to serve northeast Colorado are provided by the Legal Services Corporation. Contact with nationwide Migrant Legal Action is maintained through a regional MLAP lawyer based in Denver.

Most of the legal problems encountered by migrants involve difficulties related to employment, housing, and social services. Non-payment of wages is the most frequently reported problem. Workers are hired for two hoeings of beets, and many are not paid after the second hoeing. This type of dispute is usually settled through direct contact by the lawyer to the farmers. Another work-related problem is that of over-recruitment of migrants by farmers and crew leaders. As a result, many migrants who have been promised jobs have no work when they arrive in Colorado.

At present, there is no legal recourse available that would alleviate the lack of housing for farmworkers. Many migrants work the entire season without any kind of housing. The few houses that exist are badly deteriorated and not being repaired. However, employment is such a necessity for migrants that they will accept it without housing.

Problems with the Weld County Department of Social Services usually concern certification for food stamps. Although regulations allow for simple processing of migrants' applications, individual technicians often apply alternative, more stringent, procedures thereby delaying or denying food stamp certification.

The lawyer maintains close contact with the Colorado Migrant Council and informs the council of new regulations affecting migrants. The effectiveness of the lawyer and his staff is enhanced by an awareness of the varying concerns expressed in the cases handled.

Farmworker Organization

The Colorado Migrant Council (CMC) state office in Denver coordinates migrant affairs throughout Colorado. Several regional offices, including one in Weld County, coordinate migrant affairs on the regional level. CMC offers the range of farmworker employment and training provided by its CETA funding. Also, CMC has been the major provider of migrant day care in Colorado for ten years, utilizing funds from both OCD and DOL. Although funding cuts of 10% in the DOL budget have necessitated a reduction in total services, care was extended to cover additional children this past year. As funds are reduced, CMC will be forced to reduce services correspondingly unless additional money is made available from other sources. CMC is encouraging the local DSS offices to purchase day care services for migrant children.

The Colorado Migrant Council office for northeast Colorado is in Weld County. Services available through the CETA 303 program include instruction at Aimes Community College, job development and placement, and outreach to migrant families. In 1976, CMC administered two day care centers for migrant children in Weld County. One of these centers was operated through the local Chicano Community Center. Day care services are coordinated with Title I Migrant Education through the joint use of facilities, and through the cooperative use of outreach workers. CMC utilizes community resources in its programs whenever possible.

Many creative ventures have been organized by the Weld County CMC with the purpose of increasing the independence of migrants. Some activities involve educating personnel of local institutions to sensitize them to migrant needs and offer practical suggestions for service programs. For example, CMC is planning a hunger workshop with the local DSS to dramatize the need for a food bank. In addition, CMC is beginning to buy food in bulk in order to serve migrants who cannot obtain food stamps from DSS without delay. Many migrants are not eligible for food stamps at their home base in Texas and thus do not have transfer forms to present to DSS for immediate certification. CMC also holds fund-raising events periodically to support the emergency services it provides.

The CMC director is working with a group of local service providers to form a local coalition of those who serve migrants. He is also a member of the Colorado Occupational Safety and Health Agency. To address the critical housing needs of migrants, the CMC director is proposing the establishment of a family camp to include Head Start day care facilities staffed by University of Northern Colorado students. CMC is also considering the creation of several migrant agricultural projects.

At the state level, CMC, in conjunction with the National Association of Farmworkers, has developed a computerized system, the Data Base Information System, designed to simplify for migrants the process of establishing eligibility for services. The system also will greatly reduce paperwork for agencies using it and will allow for better use of staff time. The system will hold up to 250 pieces of information on families which can then be matched with eligibility requirements for various services. It will keep separate records for Head Start enrollment and health information. In addition, descriptive information on available housing and a current list of farmwork in the state will also be computerized and provided to migrant families.

Information is coded and available to service agencies, with the health information held confidential and accessible only to physicians or health researchers. To ensure maximum accessibility to service providers, computer terminals will be placed in different geographic areas around the state. The Data Base Information System was scheduled to begin functioning on a limited basis in November 1976.

CMC coordinates with other agencies serving migrants at the state level through the Colorado Migrant Coalition. One notable link that exists is that of CMC with the executive director of the state Department of Labor and Employment (DLE), who is striving to rectify Employment Service in Colorado in response to the Judge Richey decision in NAACP vs. Brennan (NAACP, Western Region, et al. vs. Peter J. Brennan, Secretary of Labor, U.S.D.O.L., et al. Civil Action #2010-72, August 9, 1974). A special bilingual/bicultural assistant serves as an advisor on implementation of corrective action by the DLE. One basis for cooperation between CMC and the DLE is that farmers as well as migrants suffer from the relationship of employment to housing. Farmers who use the Employment Service to recruit workers must provide housing as a condition of employment. As most farmers do not have housing for workers, they do not use the Employment Service, and thus only a limited number of jobs are listed with the service. The Employment Service, therefore, serves neither the migrant nor the farmer satisfactorily. The DLE Executive Director is requesting $100,000 from the State of Colorado for the purchase of mobile vans to coordinate crew leader registration, housing information, and job opportunities.

It was suggested by the DLE that federal money for migrant and farmworker programs go directly to governors' offices throughout the country for coordination and funding of programs.

State Service Provider Agencies

Social Services

A full range of social services is provided throughout the state by the Department of Social Services, with the exception of day treatment and foster day care. The Title XX program in Colorado allows for variations in services and eligibility requirements from county to county. Weld and Pueblo counties submitted separate modifications of the state service plan which are included in the state Title XX Comprehensive Plan. For fiscal year 1977, Title XX of the Federal Social Security Act makes available to Colorado over $29,000,000 in federal funds to provide services to low-income individuals and families.

In Colorado, providing day care for migrant children with Title XX funds is more of a problem than in most states because the state plan makes day care available only to those families with a single parent who is either employed or in an educational training program. The exception to this rule exists in Weld County where, if both parents work a combined total of 60 hours a week or more, their children are eligible for day care services. According to the Title XX Director, Migrant Head Start funds have been decreasing with the expectation that the state will provide additional day care funds through Title XX. The state legislature, however, has not allocated money for program expansion.

The number of migrants receiving services is not known since migrants are not identified separately. The state protective services consultant noted that protective services are provided in all reported cases. If a child is abused or neglected, any needed social service will be provided, regardless of family income. The Migrant Council estimates there were ten cases of child abuse or neglect among migrants in Colorado in 1975.

There is some evidence that social services are made available to people of limited English-speaking ability. The department employs fifteen bilingual people throughout the state; eleven of these work in food stamps operations. Whether any are former migrants is not known as they are not identified as such.

Migrants could have some influence on state programs through the participation of the Colorado Migrant Council on various social services boards. It was stated that CMC could have input into the State Board of Social Services, the policy-making board. The State Advisory Committee to Social Services has had a CMC member in the past but that position was vacant in late 1976.

There have been various difficulties in planning Title XX services in Colorado. These are described as follows in the Comprehensive Annual Services Plan:

> Rather than Title XX being a vehicle for better coordination between programs, it is serving to further fragment the human services system... The pressures exerted by special interest groups and other similar groups are influential in determining the distribution of Title XX dollars through the legislative appropriation process. Although these groups represent people who do need social services, the pressures seem to be causing imbalances in the system (Colorado, CASP, p.75).

The director of the Division of Title XX services stated that in Colorado the percentages of funding for Title XX are as follows: 75%, federal; 5%, state; and 20%, county. All the state money spent for social services, including the 5% for Title XX, costs Colorado two dollars for every federal dollar received. The state continues to increase its spending to maintain existing programs, but the state legislature will not fund any new programs. The state Title XX director indicated that Colorado's population is not increasing; because federal Title XX allocations are based on population, Colorado's Title XX funding also will not increase. It was stated that a line item for migrants within the Title XX plan, which would earmark a certain amount for services to migrants, would cause a reduction in services provided through other programs.

Child Care

The Colorado Migrant Council has been providing day care for migrant children for ten years. Despite CMC provision of day care to 1,500 migrant children statewide, approximately half of the eligible children, ages two weeks to five years, remain unserved. Currently, the CMC uses both CETA 303 and Migrant Head Start funds. CETA 303 contributes two hundred dollars for each child of students in CETA programs. The current CMC grant applications to OCD and DOL reflect this joint funding arrangement.

Children qualify for day care if their parents are migrant farmworkers, seasonal farmworkers, income eligible, or meet the Community Services Administration poverty guidelines. The CMC migrant family profile for 1975 indicated that there are 2,210 migrant children between the ages of one week and five years in Colorado. CMC served 1,058 of these children in that year. In 1976, CMC served 1,500 children without an increase in funding. Some of the centers have waiting lists because there is insufficient space.

The curriculum and operations of CMC day care centers are planned to meet the needs of migrants. Each center utilizes the Migrant Head Start curriculum. The hours coincide with parents' working hours, and transportation is provided. Sixty-two of the 147 staff members statewide are migrants or former migrants. CMC and Title

I Migrant programs collaborate in providing outreach to families needing day care services.

Staff development for the CMC child care centers was scheduled in the various areas of the state to precede the week of the centers' openings in the summer. Additional training was provided throughout the season.

There is close coordination with Title I Migrant throughout the state, especially in the northern area, where CMC day care and Title I Migrant Education share facilities. CMC contracts with Title I Migrant to provide transportation in most cases. Title I also coordinates its migrant identification project with CMC, and has located migrants in a few areas where there are no day care programs.

Despite its long history of providing day care, CMC still experiences difficulties with the operation and management of the programs. One concern is the licensing of centers. Although centers are permitted to begin operating when needed, licensing delays are often as long as two months.

Delays pose problems, but a delay is seen as a mixed blessing because, according to CMC, "The regulations make no provision for migrant and seasonal programs and, if enforced, would effectively curtail such operations."

The arrangement with Title I Migrant to place day care centers in schools with Title I Migrant programs ensures the coordination of transportation. However, this makes the program dependent upon the school schedule, and necessitates a closing for major school cleaning in the early fall, a peak farmwork period.

The use of CETA as a funding source is problematical also. Although CETA funds may provide day care for children of CETA students, DOL reduces the funds by 10% each year. Thus, progressively less money is available for day care. CETA is understaffed and needs to place its priority on the education of adults for which it is mandated.

Substantial help from the Department of Social Services does not appear to be forthcoming. As long as Colorado counties have the right to individualize their social service plans, local attitudes toward migrants will continue to influence the amount of social service money that is available for day care to migrants.

Education

There are a small number of locally funded bilingual/bicultural projects which serve migrant children in the state, but the largest provider of educational services for migrant children is the Title I Migrant program. The MSRTS indicates a total enrollment of 4,676 between the ages of six and eighteen. The summer program runs for eight weeks, and the length of the school year program varies depending on the number of students staying. Generally, some migrant students stay until November and then return again in the spring. In an effort to match parents' working hours, Title I Migrant directors schedule the school day from 7:30 or 8:00 a.m. until 4:30 or 5:00 p.m. The majority of the migrant students are in the primary grades, so there is an emphasis on the program for that age group. There is concern for older students as well, and Title I Migrant provides work-study programs and evening classes to make the program attractive and economically feasible. A special incentive is needed to encourage migrant youths to continue their education because farmwork in the Arkansas Valley is relatively well paid, and growers hire the older children to work.

Migrants are involved in the Title I Migrant program in several ways. There are bilingual and former migrant personnel on the staffs. Parents also assist in planning and evaluating Title I Migrant at both the state and local levels. Parents and principals are brought in to help develop the state migrant education plan. Parent Advisory Councils composed of migrant members then review the plan at the local level. Title I Migrant programs also coordinate with CMC and provide transportation for parents' nights, which are held once a week at the schools during the summer.

The Migrant Student Record Transfer System is reportedly becoming more useful in transmitting information about pupils. Since the effectiveness of the system is dependent on its use by local personnel, the state director works to promote its use among the teachers. The health portion works well, but the academic information is less useful because teachers often prefer to utilize their own tests in evaluating children's academic achievement. In an attempt to improve the effectiveness of the MSRTS, the Migrant Education staff in the western states are beginning to list mathematics skills by objectives and hope to develop a similar set of objectives for reading skills. With the skill levels indicated by objectives, teachers may not always need to evaluate children entering a program.

Since 1973, the Title I Migrant Identification and Recruitment project has been working to identify and recruit all migrant children of school age in Colorado. The outreach workers also refer families to any needed social services.

The state Title I director feels the present level of involvement in day care cannot be exceeded. The Migrant Education program secures the use of public schools in most locations, coordinates transportation, and records the children in day care on the MSRTS. The program lacks sufficient funds to provide day care. Money must go for school-aged children first, and the remaining funds are inadequate for day care.

Title I Migrant is active in program development on both the state and local levels. It will soon publish a comprehensive directory of migrant services. A less complete version is currently published by the

Coalition of Agencies, a group of about forty agencies concerned with human services; Title I Migrant is a member of Coalition. This year, the state Coalition held regional meetings to encourage the formation of local coalitions throughout the state.

Several problems which interfere with the ongoing operations of migrant education are in the process of being resolved through contact with other service providers. The August closing for school cleaning affects the Title I Migrant program as well as day care in Colorado, and the closing comes when there are still many migrant children in the area.

The Title I director is exploring the possibility of requesting that the major school cleaning be done in the late spring. Title I summer programs would then begin two weeks later and continue through the fall without a break.

An additional problem mentioned was continuing education for older students. A discrepancy exists in the number of credits required for graduation in the different states. Title I Program staff in Washington and Texas are in the pilot stage of a project to work out a credit exchange so that students can graduate wherever they are attending school.

Interstate coordination of migrant education programs is still difficult. Since Texas is the home base for most students in the midwestern states, it is felt by the education staff in Colorado that Title I Migrant staff in Texas should take the initiative in establishing better interstate coordination of Title I Migrant Education.

The Colorado staff of Title I Migrant Education has extended their concern for migrants to service areas outside of education. The lack of migrant housing and the lack of hospitalization insurance were cited as the most severe problems faced by migrants. Issues such as these are being studied by the Coalition of Agencies.

Health

In Colorado, migrant health programs generally operate within public health facilities. Patients are seen by private physicians who are paid on an hourly basis rather than by fee-for-service. Specialists are available at Colorado General Hospital in Denver. Hospitalization is available there under requirements of the Hill-Burton Act even when a migrant carries no insurance for hospitalization. The total number of children seen by the migrant clinics statewide was 4,497. A portion of these services was contracted for by CMC, which provides day care and Title I Migrant Education. The full range of health services was available to migrant children with the exception of EPSDT, maternal and child health, (available from county health departments), and WIC, (available in only a few counties). On a statewide basis, the most common health problems among migrants are strep throat, pediculosis, upper respiratory infections, poor vision, otitis media, and dental problems.

Each area has a full-time nursing coordinator who is responsible for overall health care for preschool and school-aged children year-round. There are also 21 part-time nurses who are employed in the summer to provide screening and assessment of Title I Migrant children. Two former migrants serve as community workers and provide assessment and referral. Outreach is coordinated with Title I Migrant programs and the Colorado Migrant Council.

In 1976, all the health screening for migrants was done by a mobile team, headed by a physician, and including the services of medical, dental, and nutrition students through a grant from the Johnson Foundation to the University of Colorado. The team covered the state, worked with local migrant health doctors and nurses, and provided education and counseling for the local staffs as well as medical care for the migrants. This program was widely acclaimed by those who were familiar with it as being thorough and concerned with the total well being of patients. The grant expired at the end of the 1976 season, and a group of state agencies, hospitals, and universities planned to present a special request to the state legislature for funds to continue operating the program seasonally.

Throughout Colorado, services appear to be well coordinated at both the state and local levels. The farmworker organization (CMC) is responsible for initiating many of the current cooperative efforts; several other service providers have developed notable components which have greatly enriched the basic provisions. Title I Migrant Education involved many groups in the production of its migrant olympics and coordinates its services with those of the state bilingual/bicultural education projects for added benefits to migrant children. Also of interest are many evening programs planned for teenagers which enable them to work and continue their education.

Migrant health providers have sought funds from several federal sources in an effort to support expanding programs. Funds are now being requested through the state legislature in order to continue the statewide health screening program, formerly funded by a grant.

The unusual concern demonstrated by the state Department of Labor and Employment has helped to develop close ties with the Colorado Migrant Council and is likely to produce changes to increase the usefulness of the employment service for migrants. Several state-level respondents stated that interagency efforts are somewhat handicapped by their own priorities. Full coordination of service provision to migrants may require an agency to focus less on its own priorities and more on the total well being of migrant children. It was suggested that good coordination at the federal level could serve as a model for state-level agencies.

CHAPTER III

FLORIDA: COLLIER COUNTY

As the home base state for most East Coast stream migrants, Florida has a large migrant population. An estimated 35,000 migrant farmworkers live in Florida, and during the summer, travel to all southern and eastern states and as far west as Arkansas. Agriculture is a major business in the State, with tomatoes and citrus fruits the most important crops. Florida ranks second in the nation in the average net income earned by individual farms. Between 1970 and 1976, agriculture in Florida was a growing industry; citrus and vegetable yields and profits were increasing steadily even though the total acreage devoted to these crops was decreasing.

The ethnic composition of the migrant farmworker population in Florida is shifting. Formerly, the migrant population was predominantly Black. In recent years, there has been a significant increase in the number of Mexican Americans, and it is estimated that persons of Hispanic origin are now in the majority. Recently, an increasing number of Florida migrants have traveled independently, either alone, or with family groups, and fewer have traveled as crew members.

Collier County, in southwest Florida, has the highest concentration of migrants--an estimated 17,000--with the majority in the city of Immokalee. Citrus fruits, tomatoes, and vegetables are the major crops grown in the county. The peak farmwork season is from January through March, although crops are grown year-round in the area. Mexican Americans predominate among migrant farmworkers who live in Collier County.

Services and Needs in Collier County

The need for services and the pattern of service delivery to migrants is somewhat different in a home base state than for an in-stream state. Services are needed over longer periods of time since migrants live at the home base for half the year, or more, whereas their time of residence in each state in-stream is shorter. Some migrant family members may reside year-round in the home base state while other family members work in-stream part of the year. The clientele for services differs somewhat in a home base state. For example, there may be higher percentages of children who need services in Florida than in up-stream states because not all migrants travel as families.

Social Services

Social services are provided in Collier County by the Division of Family Services (DFS), a unit of the statewide Department of Health and Rehabilitative Services. The county-level DFS conducts eligibility screening and then refers social services clients to the appropriate provider. The DFS has offices in Naples and Immokalee. Eligibility requirements are the same for migrants as for nonmigrants. Agency personnel reported that there is no problem with undocumented workers in the area.

The DFS offers a full range of social services through funding derived from Title XX monies. It is difficult to determine the number of migrants served because the record-keeping system does not report on utilization of services by migrants. Protective services are provided to anyone who needs them. Staff members reported that no special efforts are being made to increase migrants' awareness of the availability of protective services, and the agency is doing nothing to increase public knowledge of the special problems of migrants.

Service delivery to migrants is limited. In Collier County, no special provisions are made to facilitate the access of migrants to services. There are two bilingual persons on the DFS staff, one a social worker hired to provide general services and the other a social worker in charge of protective services. No one is assigned to deal specifically with migrant clients. Some measures are taken to provide continuity of care to migrants. Agencies in-stream are informed about migrants who will be needing services. DFS staff utilize a migrant tracking system to ensure continuity of health care when an extreme emergency has affected a migrant child.

Program management activities are limited. The DFS receives migrants on referral from the state and county health departments, the migrant clinic, farmworker organizations, and local schools. DFS staff members also participate on the Collier County Interagency Council, a coordinating body comprised of public and private service providers which meets bimonthly to exchange information on social services. There is no local-level policy-making board for the DFS. There are no contracts for services, either to farmworker organizations or to other social service providers. No information was available on program development activities, such as staff training and in-house or contracted research projects related to migrant child welfare.

A number of problems were identified concerning social services to migrants. A DFS employee reported that the agency meets only 15% of the need for services among all children, migrant and nonmigrant alike. The responsibility for service delivery lies with local governments, and staff indicated that this responsibility should shift to the state government in order to make more resources available. An additional rationale presented for having responsibility for social services reside with the state government is that local control makes it possible for local governments to limit services when their constituencies have little interest in providing services.

Several other agencies provide social services to migrants in Collier County. Two church-affiliated groups, Redlands Christian Migrant Association (RCMA) and the Catholic Services Bureau of Collier County, and two farmworker organizations, Community Action Migrant Program (CAMP) and Organized Migrants in Community Action (OMICA), operate programs with social service components. The services provided by the church-affiliated organizations are described here, and the farmworker organization programs are discussed in a separate section below.

The RCMA, a private nonprofit organization, is very active in providing services to migrants and particularly to migrant children. This agency provides day care and supportive services to more than one hundred migrant children in Immokalee through Title XX funding. The day care programs are described in detail below. There is high migrant involvement in programs of the Association. All employees of RCMA are migrants or former migrants, and seven migrants sit on the nine-member board of directors. This agency also acts as an advocacy group, and has prepared position papers on national policy toward migrants. In addition, its personnel attend state and local meetings about migrant issues and work actively to increase public awareness of migrants and their special needs.

A local voluntary agency in Naples, Catholic Services Bureau of Collier County, provides some social services to migrant children as well as to nonmigrant children. Foster care, counseling, a big brother program, emergency assistance, and outreach are available to all persons as there are no eligibility requirements. Most of the migrant children are served between November and March which is the period they are residing in the county. The programs of the Bureau are funded by the United Fund and the Archdiocese of Miami. A former migrant has been hired as a community aide to work with the migrants and provide some outreach services. One migrant is a member of the board of directors. The Bureau coordinates with the state DFS in carrying out its programs, and participates in the Collier County Interagency Council. Staff members reported a number of problems in serving migrants. First, the Bureau is located in Naples, some 45 miles from Immokalee, so transportation difficulties limit migrants' access to services. The lack of outreach services and the fluidity of the migrant population pose difficulties in serving migrants. Staff members reported that the extent to which their programs meet the needs of migrant children is "very, very low." The inclusion of migrants in the service delivery and policy-making levels may lead to an increase in services to migrants in the future.

Child Care

The major providers of day care to migrant children in Collier County are the statewide Community Action Migrant Program (CAMP) and the Redlands Christian Migrant Association (RCMA), a private nonprofit organization. CAMP operates two Head Start centers in the county, one at a labor camp in Naples and one in Immokalee. These centers serve children, aged two to five, from 8:00 a.m. to 2:00 p.m. The migrant children served by the CAMP Head Start centers are Black, White, Indian, and Mexican Americans. The curriculum focuses on reading and other basic skills, and follows that of the Head Start curriculum guidelines. The Head Start program is run as part of the CAMP Child Development program which includes educational services, nutritional and other supportive services, and participation of migrant parents. Health-related services provided to Head Start students include medical and dental examinations, immunizations, health referrals, and health education. Some of the children also receive health and dental treatment. Funded presently by HEW Head Start monies, the future of CAMP-operated Head Start programs is somewhat in doubt since the organization lost its DOL funding in January 1977.

A majority of the CAMP Head Start staff are migrants and former migrants. CAMP provides extensive outreach services which affect Head Start programs as well as other CAMP services. Recently, the farmworker organization was able to hire additional outreach workers with USDA matching funds. Program management activities focus on staff training according to the Head Start training plan and are handled as part of the overall operations of CAMP rather than through the Head Start centers themselves. The Head Start centers coordinate with health care providers.

RCMA operates one day care center in a labor camp, serving 44 children, aged two weeks to five years, between the hours of 6:30 a.m. and 5:30 p.m. RCMA provides before- and after-school care in Immokalee from 7:00 a.m. to 5:00 p.m. Eighty mostly Spanish-speaking children between the ages of three and eight are served in double shifts, 40 in each shift. This is the only identified organized source for before- and after-school care for migrant children.

The goals of these two day care programs are to provide an educational curriculum, to promote language development, and to develop a positive self-image in the child. Supportive services include immunizations, physical examinations, health screening, health referrals, and psychological counseling for all children. Eligibility for the service is based on family income, and fees are scaled. RCMA day care programs in Collier County are funded with Title XX monies.

There are many bilingual persons among the staff, all of whom are former migrants. Every effort is made to maintain a racial/ethnic balance on the staff, and Black, White, and Hispanic persons are included. Specific information on outreach activities is not available, but the RCMA day care services are highly accessible. The day care center is housed within Farmworkers Village, a housing project for migrants. Migrants are also active in the management of RCMA programs, and predominate on the association board.

Program development activities are rather extensive. All staff members participate each year in eight workshops which focus on concepts of child development. RCMA conducts an ongoing in-service training program which discusses the purpose and utilization of songs, games, and other teaching tools. The utilization of teaching techniques to develop a positive self-image in children is emphasized.

RCMA, working to expand its day care services, has obtained a facility for providing before- and after-school care to an additional 80 children. A county ordinance has prevented utilization of this facility since it is contiguous to another day care center. Despite this difficulty, it appears certain that RCMA will expand its day care services in Collier County. The RCMA day care program is exceptional in the utilization of migrants as staff members, the location of facilities in migrant camps, and the comprehensive nature of the services provided.

The major problem with day care services in Collier County is, simply, that there are too few. RCMA spokespersons estimate that although more than 700 migrant children are eligible for day care in Collier County, only 124 are accommodated in the programs. The great need for day care is likely to continue.

Education

Title I Migrant Education programs are operated in 12 schools in Collier County. In Immokalee, four elementary, one middle school and one secondary school offer educational programs. The curriculum for Title I Migrant programs includes supplementary classes at all levels in language arts, reading, and English as a Second Language; early childhood programs for children aged three and four; and Learn and Earn vocational education for secondary students. Available supportive services are transportation, outreach, personal and career counseling, and social worker services. The meals program is subsidized to provide a low-cost breakfast. There is no Title I Migrant summer program in the county and no extended-day program. Funding for the Title I Migrant programs in Collier County was $1,253,000 for the 1976-77 school year.

In fiscal year 1976, approximately 3,500 children were served by Title I Migrant programs in Immokalee. Enrollments fluctuate from 1,500 in September to 3,500 during the peak winter season. All children enrolled in Title I Migrant programs are entered on the Migrant Student Record Transfer System. Program staff reported that the MSRTS is the best system possible for providing national coverage of migrant students. Utilization of the MSRTS is still unsatisfactory, and local staff are working to make more effective use of the system. School officials said that the MSRTS functions well in providing information on health status, but is less informative on academic matters. A total of 133 persons staff Title I Migrant programs in Collier County, working as teachers, tutors, and in support functions. The number of bilingual persons and former migrants on the staff could not be obtained. The Title I Migrant program employs recruiters who make home visits to identify eligible students. Outreach services consist of referrals for services.

The Title I Migrant program coordinates with social service providers to offer comprehensive services to migrant students. The schools refer them to the county health department for immunizations, health diagnosis, and treatment. Linkages with the county mental health department supplement the psychological counseling provided in the schools.

Tutoring is provided for one bilingual class at the middle school. School officials stated that more staff is needed to extend the individual tutoring services of the Migrant Education program. Tutoring is felt to be especially important for migrants because they often enter school late in the year and need extra assistance to make up for studies they have missed.

Bilingual programs are offered to migrant and other students in Collier County schools. The Title VII Bilingual/Bicultural program is available at one high school. This program serves 400 Spanish-speaking students in grades nine through twelve. ESEA Title VII funded this program for the 1975-76 school year with a special grant totalling $52,120. Title VII programs in elementary schools were discontinued because funding expired. However, most elementary schools have continued to offer similar services, and it was reported by school staff that there is "some semblance of bilingual/bicultural programs" at the elementary level. The lack of formalized bilingual programs at the elementary level is of great concern because early childhood is the most critical period for language development. Another bilingual program is funded by the Title I Migrant Education program. Given the high numbers of migrant children in Collier County and the high proportion of Spanish-speaking migrants, these few bilingual programs are not meeting the need.

Health

The major provider of health care to migrants in Collier County is the migrant health program, housed at the Immokalee Health Care Center. This program is a part of the Collier County Health Department (CCHD), and is funded through the Migrant Health Act and the Rural Health Initiative. Services provided to migrants include immunizations, screening and tests, physical and dental examinations, and hospital referrals. Special provisions of the migrant health program include transportation to the health care center and to clinics in other towns, outreach to children in schools, and use of the National Migrant Referral Project to provide continuity of health care. The county health department offers supplemental services including hospital out-patient care, services for handicapped children, and examination and treatment by specialists contracted by the CCHD. The Women, Infants and Children nutrition program (WIC) is available at the Immokalee Health Care Center and at the County Health Department office in Naples. There are no eligibility requirements for the programs of either the Immokalee Health Care Center or the County Health Department.

Figures supplied by the CCHD indicate that, during fiscal year 1976, over 2,000 migrant children were provided with dental services, immunizations, and pediatric services. In addition, 800 children were given physical examinations, 800 were provided with outreach and home health services, 300 were served by health education programs, and 450 were given screenings through the migrant health program. Migrant children were also cared for by specialists: ten children were examined by eye specialists, ten by ear specialists, and 300 were referred to other specialists. Migrant health program personnel report that these services meet the health care needs of 20% to 50% of the migrant child population of the county. The most common health problems affecting migrant children in Collier County are upper respiratory infections, impetigo, diarrhea, and otitis media.

Extensive referrals are made to the county health department for additional health services; the department contracts with doctors and hospitals to provide health care which is not available at the Immokalee Health Care Center. In fiscal year 1976, through CCHD contracts with doctors, 820 migrant children were provided with physical examinations, and eye, ear, and other specialized care. CCHD contracts with hospitals provided 400 migrant children with emergency room services and 20 crippled children with special services.

Migrants' accessibility to health care is facilitated because there are quite a few staff members who are familiar with the language and background of migrants. Eight former migrants work in health care delivery; one registered nurse, three community health workers, one dental assistant, and three clinic aides. There are ten bilingual people, including two doctors and one receptionist. Transportation is provided to the Immokalee Health Care Center and to other clinics, which greatly increases access to services. Outreach services would also extend health care to more migrants, but outreach activities were reported to be insufficient.

The migrant health program focuses on coordination with other service provider agencies. The program makes referrals to the County Health Department and the DFS. Physical examinations and immunizations are provided through coordination with the local schools. There are informal linkages with the farmworker organization. Immokalee Health Care Center representatives meet monthly with the Immokalee Interagency Council to exchange information on service delivery.

The staff of both the Immokalee Health Care Center and the county health departments identified several problems in the area of health care delivery to migrants. First, the services provided are inadequate relative to the need for health care among migrants. This situation is progressively deteriorating due to funding problems. In 1976, there was a ten percent reduction in both the migrant health grant and Rural Health Initiative funds, with further cutbacks anticipated. The lack of outreach services greatly reduces migrants' accessibility to health care, and it was urged that more funding be provided in order to conduct comprehensive outreach activities. Referrals present a number of problems for the health care providers. A great deal of paperwork is involved in making referrals, and it is difficult to obtain accurate registration information for making referrals to hospitals. Also, there are no funds to pay for migrants' hospitalization. Although these problems are basically the same as those affecting migrant health programs across the county, Collier County is a home base for migrants and the number needing health care is greater than in many other places.

Farmworker Organizations

There are two farmworker organizations in southern Florida, the Community Action Migrant Program (CAMP) and Organized Migrants in Community Action (OMICA). The major purposes of both organizations are to promote better living conditions for migrant and seasonal farmworkers who choose to remain in agricultural work, and to provide alternatives for farmworkers who wish to settle out of the migrant stream. Each organization operates on-the-job training and manpower programs and offers a variety of supportive services. CAMP was founded in 1965, and serves a nine-county area in southern Florida with a migrant population of about 120,000. OMICA was established in 1967, and serves 30,000 migrants in Collier and Dade Counties. The funding sources for CAMP programs include DOL (prior to 1977); HEW, including the Indian and Migrant Program Division; CSA; and Community Coordinated Child Care of Palm Beach County. OMICA programs are funded by DOL-CETA Title I and private donations.

The supportive services of CAMP include a child development program that provides day care and Head Start services to 550 migrant children in southern Florida. Health diagnosis and care, meals, EPSDT, and health education are also part of the program. (The child development program is described in detail in the Child Care section of State Service Provider Agencies, below.) Additional services provided by CAMP to migrants include relocation and emergency assistance, family counseling, outreach and referrals, youth services, alcohol rehabilitation, and facilitating access to food support services. CAMP also operates a Senior Citizen program that includes referrals to services, provision of daily hot meals, and cultural and recreational activities.

Program management activities of CAMP focus on coordination with other service provider agencies. CAMP regularly refers migrants to the migrant health clinics and DFS. The organization also participates in interagency coordinating groups, such as the Immokalee and Collier County Interagency councils. Staff training is a major activity in the area of program development. CAMP provides training in early childhood development for its day care and Head Start staff. The organization is seeking to expand its child care services and has applied for additional Title XX funds for this purpose.

CAMP spokesmen identified a variety of problems and needs which affect migrant and seasonal farmworkers in Florida. Three CAMP representatives reported that there is discrimination against farmworkers in provision of services because of their migrant and minority status. To remedy this problem, they suggest that eligibility requirements for services be eliminated and that non-discrimination laws be enforced.

Most migrant children work in the fields. CAMP employees stated that this problem should be attacked by enforcing child labor and school attendance laws, developing outreach to identify working children, and transporting them to day care centers. Child welfare services were felt to be inadequate. Title I Migrant Education programs operate from 8:00 a.m. to 2:00 p.m., but parents work from 6:00 a.m. to 6:00 p.m., so many young children are left unattended for parts of the day. Several people reported that there are only minimal programs to provide day care for infants and toddlers or before- and after-school care for school-age children. There is a general lack of funds for day care and educational programs for migrant children. An administrative problem that adversely affects services for migrants is documentation of eligibility for services. The paperwork required is extensive, but also eligibility must be certified in Tallahassee or Jacksonville. It was stated that service delivery would be greatly facilitated were it possible to arrange for on-site eligibility certification.

In January 1977, the DOL refused to renew $1,500,000 in funding to CAMP. These funds had supported CAMP's manpower programs and accompanying supportive services. The future of CAMP services in these program areas is not yet known.

The supportive services of OMICA include family counseling, referrals to services, emergency relief, nutrition counseling, high school dropout prevention, and the Everglades Trailer Project, a housing program. OMICA is especially active in facilitating migrants' access to food stamps. In Homestead, 85% of the clients who obtain food stamps go through OMICA first. OMICA publishes "Nuestra Lucha," a bilingual newsletter on migrant issues, with circulation to migrant camps and service providers at the state and national levels. The organization also has a research component which conducts studies to document the problems of migrant farmworkers in order to obtain funding for new programs. One such study, "OMICA Research: An Overall View," was published in August, 1976, and presented the results of a survey made of 150 migrant households in south Florida. The survey provided a demographic and economic profile of migrants, and discussed their utilization of services and needs in the areas of housing, education, and health. Since August 1976, OMICA has been active in providing food and clothing emergency assistance for 1,300 migrant farmworkers adversely affected by 1976-77 weather conditions.

State Service Provider Agencies

Social Services

The state Department of Health and Rehabilitative Services (DHRS) is the major provider of social and health services in Florida. Formerly, eligibility certification was processed through state offices in Tallahassee, but an agency reorganization has facilitated delivery of services at regional and local levels. DHRS clients must be citizens, AFDC clients must be Florida residents; and protective services are available to all persons. As of July 1976, 97% of the federal Title XX funds allocated to the state of Florida were utilized.

The DHRS offers a full range of social services. The three major budget items of DHRS are day care, foster family care, and protective services. A variety of services are provided as part of the foster family care and protective services, and include institutional care, chore services, family planning, and homemaker services. Protective services maintains a central child abuse registry, but migrants are not identified as a subpopulation on this registry. Agency records identify migrant clients, but do not record which services are utilized by migrants.

Outreach services are included as part of the Food Stamp program. One outreach worker is assigned to each of 11 service districts statewide to recruit more people for the program which currently serves 251,000 households. It was reported, however, that outreach to migrants for the Food Stamp program is minimal. DHRS reported that there are no former migrants on its staff and the number of bilingual people is unknown. The absence of former migrants on the DHRS staff and the lack of outreach workers for the Food Stamp program point to a generally low degree of emphasis on outreach.

Program management and program development activities of DHRS are few. The agency has few contracts with other social service providers. There are no staff training programs. The major focus of program management is in the area of interagency and intra-agency coordination.

Child Care

Various organizations provide day care and Head Start services to migrant children in Florida. By far the largest program is operated by Title I Migrant Education, which serves approximately 4,900 migrant children statewide, the majority between the ages of three and five. Other day care providers include Redlands Christian Migrant Association, Community Action Migrant Program, East Coast Migrant Head Start (ECMHS), Agricultural Labor Program, and Coca-Cola, which serve a total of 1,600 children. CAMP and ECMHS operate Head Start programs as part of their day care services. Funding sources for these child care programs include Title I Migrant Education, Title XX, HEW, and state funds.

Child care facilities for migrants are located throughout Florida, but are concentrated in the southern half of the state where the largest population of migrants is found. Child care programs usually operate from October through June, the peak farmwork season in Florida. An attempt is made to operate programs during the working hours of migrant parents, but this is not accomplished in all cases. ECMHS-sponsored programs are probably the most exemplary in this regard, since their child care services operate from 7:00 a.m. to 6:00 p.m. Preschool programs operated by Title I Migrant give priority to five-year-old children who are not already being served by the regular school program because ages for enrollment in public school kindergartens vary from county to county in Florida. RCMA is the sole provider of before- and after-school care in the state. Its services in this area are limited, and reach about

20 children, aged six to eight years, serving a total of 80 children aged three to eight. Care for infants and toddlers (children between the ages of two weeks and thirty months) is provided by Title I Migrant CAMP, RCMA, and ECMHS. The number of children provided with infant and toddler care statewide totals approximately 250. Virtually all day care programs have an educational component, and Head Start programs, of course, follow the standardized Head Start curriculum.

A number of supportive services are provided as an integral part of most child care programs. Meals and transportation to and from the facility are the most common additional services. Most programs provide some health services through coordination with migrant health programs and county health departments. Referrals may be provided to social service agencies and other health care providers. The major provider agencies have outreach workers on their staffs, and so it may be assumed that outreach provided to migrant families is for the purpose of enrolling children in child care programs.

The involvement of migrants in day care programs in Florida is relatively high. Migrants or former migrants participate in the programs at the policy-making, management, and program implementation levels. The state director of Title I Migrant programs is a former migrant. All of the RCMA day care staff members are migrants or former migrants, and seven of nine RCMA board members are migrants. About 90% of CAMP day care personnel are of migrant background; and ten migrants participate on the 23-member policy-making board. ECMHS has a policy of recruiting and hiring migrants for its day care staff. No data were obtained which would indicate the nature or extent of parental involvement in migrant child care programs. Coordination with other programs and organizations is an integral part of child care services in Florida. Most providers coordinate with various health care providers, and programs operated by advocacy groups, such as CAMP, RCMA, and ECMHS, provide referrals for social services as well.

It was reported that Florida has no state licensing agency to regulate day care or Head Start centers. In order to operate, a center must obtain a permit rather than a license. The standards for permits were not reported. Since most states do control licensing for day care facilities, Florida is unusual in this regard.

The major needs in day care services in Florida are for expanded programs to accommodate more children, and for programs to serve infants and toddlers. Many migrant children in need of day care or Head Start are not served by present programs. ECMHS personnel stated that no current programs even begin to meet the overwhelming need for infant and toddler care. Further, those programs that do serve infants and toddlers were reported to be inadequate. Funding poses an additional problem for child care providers. According to ECMHS personnel, the cost of preschool day care averages ten dollars per day per child, including transportation costs. The cost of infant and toddler care is somewhat higher. At present, Title XX funds from the state DFS reimburse day care providers at a rate of

$5.50 per day per child. As a result, provider agencies must seek funds from other sources. Although RCMA and ECMHS programs are expanding, these providers alone cannot meet the increasing need for preschool care. Before- and after-school care reach only 20 children, ages six to eight, so this need is virtually untouched.

Education

Title I Migrant Education programs are operated during the academic year in 26 school districts in Florida. In summer, there are no migrant education programs because most Florida migrants are working in-stream. These programs served more than 42,000 migrant children in fiscal year 1976, according to state officials. (Federal records indicate only 32,000 served; for clarification please see Education chapter.) Educational services provided specifically for migrant children include the Early Childhood Learning Program for age three and four, the Language Arts Tutorial Program for grades kindergarten through three, and prevocational Learn and Earn Programs for secondary school students. The early childhood program operates from 7:00 a.m. to 5:00 p.m. and includes an educational curriculum, recreational activity, medical and dental services, and daily meals. The Learn and Earn program trains youths 12 to 17 in marketable occupational skills, and works to develop the students' self-confidence and ability to function effectively in work situations. Children in grades kindergarten through three comprise the vast majority of Title I Migrant students; the Learn and Earn program has the lowest enrollment of the three programs. The only supportive services for all Title I Migrant students are outreach, MSRTS, and social worker services. Additional supportive services, such as health screening and treatment, free breakfasts, day care, career counseling, and vocational education, reach only limited numbers of students. Title I Migrant Education programs are administered by the Florida Department of Education. The budget was $12,000,000 for the 1975-76 academic year.

The priority age group for Title I Migrant Education programs in Florida includes children of preschool age through third grade. The programs targeted for migrant children in this age range include early childhood learning to prepare children for first grade, and individualized instruction in reading and language arts. Again, recent studies conducted in Florida have shown that children provided with preschool programs have greater success upon entry into grade school. Because Title I Migrant outreach workers go to migrant camps to identify and enroll eligible children, and all eligible school districts have applied for Title I Migrant funding, it is assumed that the program currently serves the majority of eligible migrant students. Program officials reported that the MSRTS gives a valid count of the number of children served by Title I Migrant and is effective at reporting health information. However, it also was reported that the MSRTS could be more extensively utilized, and in some cases, there is a lack of data.

Migrants are involved in certain aspects of the Title I Migrant Education programs. Migrant parents participate in state-level evaluations of the program. The state Parent Advisory Council includes fifteen migrant parents and ten professionals in its membership, and their recommendations are incorporated into the state education plan. The state director of Title I Migrant Education is a former migrant, but the number of former migrants or bilingual persons among the staff of Title I Migrant programs is unknown. One state and three regional offices are responsible for coordinating to ensure equal service delivery throughout the state.

Several other educational programs are targeted specifically for migrants. These include a dropout prevention program, high school equivalency degrees, and bilingual education. The Dade County School System contracted with OMICA, the farmworker organization, to develop a program with Title I migrant funds that would reduce the dropout rate and isolation of Mexican American and other farmworker students in the local schools. These students, with the highest dropout rate, felt isolated from their fellow students. The OMICA-VIDA project was developed by OMICA in consultation with an advisory committee that included migrant parents and students, community leaders, and representatives of local agencies. This program included curriculum enrichment, vocational counseling, vocational field experience, home visits by school officials, and hiring of Spanish-speaking community counselors for each of the three target schools. A total of 75 junior and senior high school students participated in this program, and their dropout rate was lowered. Student and parent involvement in the schools was increased, academic performance of students improved, and the attitudes of school staff toward migrant students became more positive (FMCCP, Annual Report, p. 3). Despite the success of this project, the contract was not renewed by Dade County, due to insufficient funds.

A high school equivalency program (HEP) is administered by the University of Miami for migrants aged 17 to 24. This program is free to migrant students who earn at least half of their income in agricultural work. Migrant students live in university housing and are provided with a weekly stipend of $10 if they attend all their classes. The program serves approximately 50 students at a time. In addition to offering educational services and small group instruction, this program provides job and educational counseling and placement. The high school equivalency program is currently funded by DOL.

Title VII Bilingual Education programs for Spanish-speaking students operate in Collier, Indian River, and Pasco Counties in Florida. These programs provide English as a Second Language instruction to approximately 800 students at all educational levels. Two ESEA Title VII grants were awarded to the Miami school district in 1975, one to establish a Spanish Language Materials Development Center serving 35,000 elementary school students, and one to provide training to teachers who serve Spanish-speaking students at all educational levels.

There are additional programs in Florida designed to respond to migrants' special educational needs. A summary of these programs is presented in the State Annual Evaluation Report, Fiscal Year 1975, published by the Florida Migratory Child Compensatory Program. Except for Title I Migrant services, most programs reach a limited number of migrants and are available only at the local level. A state-contracted study of migrant education in Florida reported: "It should be evident from the wide range of deficits characterizing migrant student performance that simply insuring equality of educational opportunity is manifestly insufficient" (D.A. Lewis Associates, Inc., Educational Needs Assessment, pp. 1-10). There is extensive and urgent need to upgrade supplemental educational services to migrants in Florida.

Health

Health services are provided to migrants in Florida through the Department of Health and Rehabilitative Services. Service delivery is administered and provided on a regional basis, as are social services also included under the DHRS. Although migrants have access to health care provided by DHRS to all the eligible public, there are also several programs targeted specifically for migrants or subpopulations of which migrants are a part. DHRS administers ten county migrant health clinics funded by the Migrant Health Act. In two south Florida counties, a demonstration hospitalization program for migrants operates under state administration.

The East Coast Migrant Health Project (ECMHP) provides health education and outreach to migrants. This federally funded program works with existing agencies in a variety of ways to increase migrants' access to health care and social services. The East Coast Migrant Entitlement Project, an experimental, federally-funded program, enrolls migrants in a health insurance plan which provides health coverage at home base and while in-stream. The Rural Health Initiative, a flexible, federally-funded program, provides health services to medically underserved rural populations including migrants. Rural Health Initiative projects are linked to existing health resources and may be used to support or expand ongoing migrant health clinics. In addition, four projects operated at the county level by other health care providers target health services to migrants. Funding for some aspects of health care has been increased in recent years. A grant from HEW was increased from $1,750,000 to $2,700,000 in fiscal year 1977.

Several providers indicated that upper respiratory infections, skin infestations, parasites, anemia, malnutrition, hypertension, and work-related accidents represent the most prevalent health problems among migrants. Foot infections, dental and visual problems, and sickle cell anemia in Black migrants are also common among the migrant population in Florida.

DHRS offers a variety of health services including immunizations, physical and dental examinations, screening, Medicaid, EPSDT, and maternal health care. These services are provided through migrant health clinics, but if such services are unavailable at a migrant clinic, then patients are referred to a county health department facility. DHRS does not include home health, outreach, health education, or child health among its standard services. Continuity of health care is facilitated by utilization of the National Migrant Referral Project, Inc., based in Austin, Texas. DHRS officials report, however, that this system provides insufficient information, and needs improvement to be effective in ensuring continuity in health service delivery.

A relatively limited number of migrants are served by nontargeted DHRS programs. Some 1,370 migrant children were provided with physical examinations by DHRS in fiscal year 1976. All other services reached fewer than 700 migrant children statewide. These low figures are not necessarily reflective of poor service delivery on the part of DHRS, but emphasize that migrants are served primarily by targeted programs operated by DHRS and other providers.

Most health care for Florida migrants is delivered through county level migrant health clinics funded under the Migrant Health Act and administered by DHRS in ten counties. Rural Health Initiative funding is also used for migrant health projects, as in Collier County. In general, migrant health projects provide primary health care to migrants and offer comprehensive health care oriented to the specific health needs of migrants. The county health departments, ECMHP, and other health service programs may be relied upon to provide supplemental health care. Migrant health projects are operated with special provisions to increase the access of migrants to health care. These services include transportation to the clinic, bilingual and former migrant staff, outreach, referrals to and contracts with other health care providers, interstate referrals, and coordination with advocacy and social service organizations. A typical migrant health program is described in "Services and Needs in Collier County," under Health, above.

The East Coast Migrant Health Project (ECMHP) operates in ten Florida counties which were identified as the areas of greatest need in terms of health care for migrants. These counties are located in the northeast, central west, and southeast parts of the state. The ECMHP is not a health care provider; rather, it works in conjunction with existing programs to increase migrant utilization of health care and social services and to upgrade the quality of life for migrants. The primary focus of ECMHP efforts is outreach. The project finds the migrant camps, and arranges for migrants to receive health care and social services. ECMHP outreach activities include providing transportation from camps to service agencies, personnel to extend service hours to provider agencies, and to improve nutrition, assistance in gaining access to food stamps. The bilingual staff helps facilitate this outreach process. In addition, the project works to ensure continuity of care by providing migrants with their own health records and counseling migrants before the summer move regarding in-stream states' services and eligibility criteria. Health education programs are also offered to migrants by ECMHP. The organization works with OSHA to promote better housing conditions and improved environmental health for migrants. Program management activities focus on coordination with other agencies.

The East Coast Migrant Entitlement Project is a unique model program which serves approximately 2,000 migrants and family members based in Florida. About 800 of the clients of this project are migrant children aged 15 and under. Approximately 75% of the program clients are Black, and the majority of the remaining clients are of Hispanic background. Under this project migrants and their families are enrolled in a Blue Cross/Blue Shield insurance plan and are informed about how to use medical resources in Florida and in-stream states as far north as New York. Thus, continuity of health care is encouraged. The insurance does not cover prescription drugs, eyeglasses, or hearing aids, and provides only limited coverage for dental care. Migrants pay a minimal fee to participate in the program; they do not pay an insurance premium. Project funds are used to reimburse Blue Cross/Blue Shield. Migrants have been enrolled in the project through the outreach services of the ECMHP and the Red Cross. The service area covers ten counties in the northeast, central west, and southeast sections of Florida. At present, it appears that this program is cost-effective and is well utilized by its clients. This program was initiated by the Bureau of Community Health Services in January 1975. Funding for the first year of operation was $378,000, and was increased to $700,000 in the second year of operation. A problem with the program has been that the DHRS, the administering agency, has been slow to reimburse the West Palm Beach Health Department, the operating agency, for staff salaries and administrative costs, to the extent that functioning of the program has been impaired.

Additional health care providers include the West Orange Farmworker Health Association, in Apopka; Community Health of South Dade, Inc. (CHI); Hastings Migrant Health Project, serving St. Johns and Flagler Counties; and the Frost Proof Area Health Clinic. These programs are targeted for migrant and seasonal farmworkers and receive their funding from federal, state, and local sources. Community Health of South Dade is the only one of these projects that provides more than primary medical care and referrals. CHI operates clinics in Homestead and in Goulds, and its services include preventive medical and mental health care, medication for post-hospitalization cases, crisis intervention, family counseling, and job referrals. CHI is able to refer migrants for hospitalization under an arrangement whereby CHI is reimbursed with county funds for hospitalization costs.

A variety of health care services in Florida including primary care, supplemental services, experimental programs, and outreach, are targeted specifically toward migrants. Given the large migrant population in Florida, it is not surprising that many health programs are available; however, whether these services meet the health care needs of migrants is as yet unclear. Florida Migrant Labor Program officials estimate that between 80% and 90% of the farmworker population is provided with basic health services (Florida Migrant Labor Program, *Farm Workers in Florida*, p. 17). On the other hand, the ECMHP has conducted need surveys for health care services and determined that Florida, North Carolina, and South Carolina have the greatest need for additional migrant health services. Even if all farmworkers in Florida were provided with basic health services, those services would be considered insufficient for any population group, but particularly inadequate for people subject to the poor nutrition, unsanitary living conditions, arduous work conditions, and environmental hazards experienced by migrants.

Additional Services

The Migrant Labor Program (MLP) Office of the Florida Department of Community Affairs acts as a coordinating body and advocacy group for migrant affairs on the state level. This office coordinates all state, federal, and private programs which serve migrants and seasonal farmworkers in Florida. The MLP cooperates with state agencies and farmworker organizations in service delivery and legislation, works with employers of migrants to improve working conditions, serves as an information center, and works as an advocacy agency for migrants in the state government. It operates field offices in Clewiston, Delray Beach, Immokalee, and Punta Gorda.

Coordination of programs is attempted through monthly meetings of the Farm Labor Committee which brings together representatives of state, federal, and private programs serving migrants. A newsletter is issued monthly or bimonthly by the MLP. This publication contains descriptions of public and private migrant programs, profiles of farmworker organizations, updates on legislation and federal hearings affecting migrants, and information about pesticides. The office also has issued a booklet about migrant farmworkers in Florida, "Farm Workers in Florida, 1976-1977," with a profile of the labor force and descriptions of housing conditions, nutrition, education, health and legal services, legislation, and private and public farmworker programs in the state.

Migrant Labor Conferences were sponsored by the MLP in 1975 and 1976. These were attended by migrants and representatives of federal and state government agencies, local governments, and private nonprofit organizations as well as program personnel from other states. The topics covered at these conferences included labor laws, food and nutrition, manpower programs, social assistance, education, and child care. Spokespersons for the MLP identified a number of problems affecting migrants in Florida. First, there are an estimated 20,000 undocumented workers employed as farmworkers in Florida. Second, many public agencies are not concerned about the problems of migrants: rather, their concern focuses on rules that inhibit delivery services. The MLP is unable to coordinate directly with people who have the authority to make decisions or to commit their program to certain courses of action. MLP staff members indicate that this lack of cooperation renders their work futile. An additional problem is that the state budget for services to migrants is low--$300,000 compared to $30,000,000 in federal allocations. Another difficulty in providing services to migrants is that there are many agencies operating diverse programs. As a result, MLP personnel find it difficult to exchange information and to gain an understanding of the programs available. It was suggested that a single agency be created to be responsible for all migrant programs.

MLP staff members feel that the particular problems of migrants--isolation, transportation, etc.--create the need for including migrants as a line item in the Title XX comprehensive plan. They felt that the situation of migrant children demands more attention because "...migrant children are a forgotten part of this society."

CHAPTER IV

ILLINOIS: VERMILLION COUNTY

Approximately 32,000 migrants travel to Illinois yearly to work in the cultivation and harvesting of crops such as strawberries, tomatoes, cucumbers, corn, cabbage, and beans. Major work areas are in the northeastern and northcentral parts of the state, with smaller concentrations in the south and along the western border. Housing generally consists of migrant camps which vary widely in quality and upkeep. Most migrants in Illinois are from Texas, and the majority return to Illinois each year.

Vermillion County is located about 120 miles south of Chicago and borders on Indiana. It is estimated that about 1,200 to 1,300 migrants worked in the fields or the canneries of Vermillion County in 1975. The primary crops are corn and kidney beans. Kidney beans are picked dry and stored for later canning, which lengthens the farmwork season. Corn, beans, and pumpkins are all processed in Vermillion County canneries. The reconstitution of juice concentrates produced by Dole canneries provides additional work.

Vermillion and Ogle Counties are major production areas, and families were interviewed in both counties. The following service providers were contacted in Vermillion County: Ayudanos-Ayudar (a day care provider), the Title I Migrant Education Program, the migrant health clinic, the Migrant Legal Action Program, a bilingual/bicultural psychologist, the Children and Family Services field office, and the Vermillion County Mental Health Center. The Illinois Migrant Council field offices were contacted in both Vermillion and Ogle Counties.

Services and Needs in Vermillion County

Social Services

In Illinois, the Department of Children and Family Services (DCFS) is separate from the Department of Public Aid, which determines eligibility for public aid, including food stamps. The Department of Children and Family Services provides social services through its area and field offices. The closest field office for Vermillion County migrants is located in Danville, about 20 miles south of Hoopeston where the largest number of migrants is found. Migrants are not identified separately by DCFS in their records; but some have been referred to DCFS for services.

The full range of services administered at the field office is available to anyone, but there was no estimate of the number of migrants served. There are no former migrants on the staff, but one of eight social workers is bilingual. No staff development, training sessions, or outreach is provided, and cases are seen on a referral basis.

The area DCFS office is in Champaign in the neighboring county. The staff provides training and technical assistance upon request and has worked with migrants in the camps to upgrade day care and housing. The office is presently understaffed and has only two people to license day care centers for a nine-county area. There is no communication with the Danville of ice about migrants' needs or services; however, the director has met with representatives from the Child Abuse and Neglect project of the Texas Migrant Council (TMC).

Major problems cited by the director of the area office were the lack of funding for enough qualified staff members, lack of bilingual staff, and lack of thorough identification of the problems in service delivery to migrant children. He was concerned that present programs are too short-sighted and suggested that long-range objectives for migrant children be considered in planning programs.

Child Care

There is sufficient day care available during the summer for all migrant children aged birth to five years. However, children were in need of day care when the centers closed in late summer. There are administrative difficulties associated with the projects. The Texas Migrant Council provided Head Start day care for 140 children. A local community group (Mexicanos-Americanos, Ayudanos-Ayudar (MAAA)), operated three programs which accommodated 88 children. The Illinois Migrant Council (IMC) in Vermillion County also purchased some slots in day care homes for the children of its CETA trainees.

The Texas Migrant Council Head Start day care programs received the full endorsement of the Illinois Migrant Council. The IMC also recommended that TMC receive sufficient funding to run programs for all migrant children in Vermillion County. The care provided by TMC was reported to be quite good and the hours, 7:00 a.m. to 5:30 p.m., were convenient for farmworkers. Relationships between TMC and the community-run MAAA day care program were strained to the point that coordination between the two programs was minimal. Several people knowledgeable about the operations of MAAA were concerned about the quality of care provided. Families in the area had heard the care was not adequate and children were not receiving sufficient supervision. One interviewer expressed doubt about the competency of the staff. The director of the MAAA centers discussed the problems freely, and many reasons for the emergence of problems became apparent.

There is no money available for start-up funds from the Department of Children and Family Services which administers the Office of Child Development Funds for migrant child care. As a result, centers must borrow money for the initial costs of beginning operation. Due to licensing and procedural problems, the openings of the centers were delayed until June. The MAAA center in Stocklin, closed because of failure to meet fire regulations, transferred the infants under its care to the MAAA center in Hoopeston. The MAAA director had little previous administrative experience, and the DCFS was late in providing staff training. The center's budget did not allow for the use of the migrant clinic for children's physicals, so they were performed by a local physician for less than the clinic's usual fees. Consequently, the migrant health nurse expressed concern that the physicals were not comprehensive, that health records had not been utilized, and that subsequent and timely entries had not been made.

When the centers closed the last week in August, there were 77 children still in need of day care. The director would have preferred to remain open until the second week of September, which is generally regarded as the end of the season. However, staffing during September is difficult because many staff members are students who return to school in the fall.

The director was informed by DCFS that for an anticipated center opening in April or May of the following year, all necessary forms should be submitted in February to allow adequate time for processing. Unless day care centers are under the sponsorship of an on-going organization which has staff time to devote to the required preparations, center directors themselves must make the necessary arrangements.

Education

The Title I Migrant Education program in Vermillion County is exceptionally well administered. Much of the credit for this goes to the local director who has 12 years of experience in migrant education. The school-year program serves a maximum of 80 students in grades K-6. These students spend a half-day in regular classrooms and the remainder in a special class which emphasizes English and the cultural aspects of the social sciences. The program is adjusted to fit the migrant season and usually operates from August to November and again from April to June.

As with all Title I Migrant summer programs, the summer program is voluntary. It involves 140 to 150 children all of whom generally stay for the eight-week duration. The hours are from 8:30 a.m. to 2:00 p.m., and transportation is provided for all students. The summer program has many attractive features including field trips, day camp for a week, and swimming lessons at a local pool.

Most of the children are from the Rio Grande Valley, and about 75% return each year. The director has traveled to the valley three times to meet with people from the home base schools where his students spend the rest of the year. He also regularly hires someone from Texas to work in the summer program to provide continuity in the program.

The majority of the staff members have been employed in the program for several years. There are three teachers, all of whom know some Spanish, and five bilingual/bicultural aides.

The director has been using the Migrant Student Record Transfer System since its inception. The system is improving, but it is reported that some schools in Texas do not enter information. There is greater cooperation from the schools that were formerly only for migrant children than from the regular schools which migrants also attend.

Coordination among Title I directors is generally good. The local director attends national Title I Migrant meetings yearly as well as the quarterly Illinois Title I Migrant meetings. Contact with the migrant council is generally limited to his frequent contacts with the migrant council clinic nurse who comes to the school. There is also coordination locally with the Hoopeston Multi-Agency Service Center, which provides referrals for needed services.

Title VII Bilingual Education funds were applied for and approved. Thus far, it has not been possible to find someone to fill the teaching position.

The director offered some historical perspective on migrant education. Twenty-five years ago, teachers went to the two migrant camps in town, at the canneries, to teach. When Title I Migrant programs began, it was very difficult to keep children in school as they were in and out of school and the fields. At the present time, students generally stay for the entire summer session with the possible exception of the time for corn detasseling.

Health

The services of the migrant health clinic in Vermillion County are available to all the migrants of the county. The Illinois Migrant Council and the County Health Department share the responsibility for the provision of health care to the migrants. The County Health Department furnishes salaries, supplies, and mileage expenses for a full-time nurse and a half-time nurse. IMC shares its facilities with the clinic and furnishes physicians' fees and other expenses. This arrangement appears to be satisfactory to all involved.

Physicians are on duty at the clinic two days a week. Much of the care seems to be provided on a personal basis by the full-time nurse who visits camps weekly providing various services, such as outreach and TB testing. She also provides care to migrant children by visiting Title I programs and the TMC day care center. The emphasis on outreach and continuity of care was evidence of a thorough health care service.

The most common health problems reported were upper respiratory infections and dental problems, followed by scabies, head lice, impetigo, and pin worms. Physicals were done for 300 migrant children during the year and home health and outreach were provided to approximately 250 children. The full range of services was provided, including dental care and a WIC program which has 250 reserved slots for migrants, but needed only 160 for the year.

The half-time nurse speaks some Spanish, and there are Spanish-speaking former migrants who are aides in the clinic. The full-time nurse who has been working with migrants for 17 years, expressed regret that there were no nurses on the staff who are former migrants as they might provide additional insight and understanding.

Major problems with health care delivery were the lack of money for hospitalization and dental care. Present funding does not allow for adequate staffing, and the nurse expressed concern that there was insufficient time spent with each patient.

Additional Services

Other services in Vermillion County available to migrants include legal aid, a bilingual/bicultural psychologist, and a bilingual Girl Scouts program.

Illinois Migrant Legal Assistance Project (MLAP) - Legal assistance is available to migrants through funds provided by the Legal Services Corporation. The lawyer has an office in the migrant council facilities and is available for consultation five days a week during the season. Although many of the problems she handles affect children only indirectly, all the problems affect children because of their impact on the family.

The major problems of migrants identified by the lawyer were termed institutional problems, that is, the problems resulting from institutional policies that do not meet the special needs of migrants. These problems center around policies governing food stamps, unemployment insurance, hospitalization, and hiring practices in public agencies.

Even though IMC staff members help applicants to fill out forms and then take the forms to Public Aid in Danville for processing, there is a 30-day wait for receipt of food stamps. The migrant council then answers any questions of eligibility. Men whose families remain in Texas have special problems in obtaining food stamps. Eligibility is based on the entire income, and no deductions are made for dependents in other states, or for rent or mortgage payments made out of state.

Unemployment Insurance - Some farmworkers are eligible for unemployment insurance under the Supplementary Unemployment Assistance Amendment. There are difficulties and delays in obtaining unemployment insurance because income verification is required from all states where the applicant has been employed. Illinois is computerizing the information and cooperating with Texas Rural Legal Aid, so perhaps the process of establishing eligibility can be shortened and simplified.

Migrants are offered some coverage for hospitalization either under a township law titled, "Aid to the Medically Indigent," or under medical plans offered by the two companies for which many of the migrants work. The lawyer aids migrants who are seeking coverage under these policies. There are no bilingual staff persons at any of the local courts nor at the nearest hospital. As a result, the accessibility of these services is limited for migrants.

Bilingual/bicultural psychologist - A special service provided at the Illinois Migrant Council in Vermillion County is by a bilingual/bicultural psychologist who works solely with migrants two days a week. The rotating position was secured seven years ago by a psychiatrist at the Mental Health Center in Danville. Originally, it was funded through CETA, but the costs were later assumed by the State Department of Mental Health. Local mental health monies also contribute to the support of the position. The psychologist helps resolve many practical problems for migrants and offers counseling to migrants who have personal and family difficulties. Outreach is also conducted and is aimed toward educating migrants about the counseling service.

Girl Scouts - The Girl Scouts program in Vermillion County has a bilingual leader who conducts meetings and activities in Spanish for migrant girls. While this program may have a small direct effect on migrant child welfare, it does demonstrate community awareness of the migrants' needs.

Farmworker Organization

The Illinois Migrant Council in Vermillion County coordinates within its facilities a wide-range of services in addition to its CETA program. The migrant clinic, bilingual/bicultural psychologist, and MLAP lawyer are all housed at the migrant council, which enhances the accessibility of these services to migrants. Through CETA, IMC provides adult education, counseling, and job placement with supportive services such as emergency food, translation, transportation, clothing, furniture, emergency aid, and referrals to other service agencies.

IMC operates a health education program, with a grant secured by the director, from Illinois Regional Medical Programs. The staff developed a 50-page bilingual book entitled First Aid, Nutrition and Health Maintenance. A course was written based on the format of the book and staff members were trained to teach families in the camps. About 28 families received 12 health training sessions. An evaluation of the program will be made by comparing the number of emergency room visits for a period of one year before and after the instruction.

The Migrant Council Office in Ogle County, west of Chicago, contacted because some of the family interviews were conducted in Ogle County, provides the same basic services as the Vermillion County office.

IMC sponsors the migrant health clinic, operates the CETA program, and provides emergency aid. The migrant day care center, named the Rochelle Enrichment Center, now operates on a year-round basis with regular funding from DCFS. The center director has a Master's degree in Early Childhood Education. The center has a capacity for enrolling 50 children and includes sufficient slots to meet the day care needs of migrants.

The Ogle County CETA program has some interesting features. Its basic program of Adult Basic Education (ABE), English as a Second Language (ESL), and General Equivalency Diploma (GED) incorporates consumer education and job skills. The director is actively seeking ways to provide good training and to secure appropriate job placements. The director has begun a cooperative venture with Kishwaukee College for a two-year training program in day care. Aides in the Rochelle Enrichment Center will receive training in the program. Discussions are also under way with Kishwaukee and Northern Illinois University to consider special vocational skills training for CETA enrollees.

Communication with other agencies serving migrants appears to be quite good. IMC staff members help families to fill out food stamp applications, take them to the Public Aid office, and request that each allotment be divided into four parts so they can be redeemed separately at local post offices. The local Community Action Agency (CAA) accepts referrals from IMC for those migrants who have not earned 51% of their income in farm work and thus do not qualify for CETA aid. The IMC director has recently been elected to the CAA board.

At the state level, the Illinois Migrant Council receives funds from DOL to administer its CETA program. Funding reportedly was sufficient for 1974 and 1975, although it is decreasing and other funding sources must be found. IMC directly administers three migrant health clinics and contracts out two, all of which are funded through IMC applications for money provided by the Migrant Health Act. IMC does not provide day care services as it receives only $10,000 for day care as a CETA support service. The organization can purchase slots, however, in existing programs. IMC was formerly the sponsor for migrant child care throughout the state with funds from Illinois DCFS. This sponsorship was terminated by DCFS in favor of direct funding of community groups. IMC still provides assistance to local groups wishing to secure funding for migrant day care.

Legal assistance is provided by IMC through MLAP funds. The lawyers use IMC office space. There had been some difficulties in Ogle County due to community reaction to lawsuits brought by MLAP lawyers. Now a closer relationship between MLAP lawyers and IMC ensures that all means of resolution are exhausted before legal action is taken.

Currently, an assessment of the number of migrants in Illinois is being conducted through cooperation between the Illinois Migrant Council, the Illinois Department of Children and Family Services, and Title I Migrant Education. It was hoped that the documentation of the number of migrants in Illinois would help to obtain more Title XX money for migrants.

However, there had been a lapse in Title XX meetings and there was some doubt whether further documentation would aid in securing money unless formal participation is sought from organizations representing the migrants.

State Service Provider Agencies

Social Services and Child Care

Social Services in Illinois are provided by the Department of Children and Family Services. The State Comprehensive Annual Services Plan states that, "Title XX does not impose residence requirements; thus, migrants do have the right to apply for Title XX services and have their eligibility determined on the basis of income and need for service" (Illinois CASP, p.8). The DCFS provides a wide range of services, but does not maintain separate records identifying the use of services by migrants. Migrants do, however, receive special attention as $20,001,200 is spent to serve 9,445 children of either low income, mobile migrant families, or public assistance families.

DCFS is also the major provider of day care for migrant children. With a grant from the Office of Child Development and state funds, 497 migrant children are served in day care centers. There are approximately 1,350 migrant children eligible for day care in the state. As there are no exact figures of the number of migrant children served, only informal estimates of need can be made.

The Department of Children and Family Services includes a migrant resource team to provide technical assistance and training to migrant day care centers. This team consists of a migrant resource coordinator, who is new to the position, a child development specialist, a registered nurse, and a resource development coordinator.

The usual DCFS procedure is to act upon requests for assistance from sponsors of day care centers. The new migrant resource coordinator stated his willingness to aid community groups in the formation stages. DCFS is also involved in a cooperative project with Title I Migrant Education and the Illinois Migrant Council to identify all migrants within Illinois. The project has already succeeded in discovering migrant work areas previously unknown to these service providers.

Presently there exists an acknowledged problem of a lack of start-up funds for those centers which operate on a seasonal basis. The State of Illinois has no procedures for meeting advanced or projected funding needs. Payments for expenditures is made only through reimbursement. Thus local day care centers may have to borrow from a bank each year to begin their programs. Greater program flexibility and immediate responsiveness were cited as the day care centers most urgent needs.

Protective services are available to anyone. Responses to reports of child abuse are made within 24 hours. There was no knowledge of reported cases of migrant child abuse or neglect as records identifying clients as migrants are not kept.

The state Migrant Affairs Coordinator is seeking ways to improve service delivery to migrants. Coordination between DCFS and IMC has been somewhat difficult since day care sponsorship was removed from IMC. The new Migrant Affairs Coordinator hopes to work more closely with IMC. The coordination with Title I Migrant programs is on a stronger footing, and potential for improved relationships between agencies appears promising. Coordination between migrant day care centers through the Illinois Committee for Migrant Children is headed by a member of the migrant resource team.

The use of a line item for migrants in Title XX was discussed, and it was felt that while it might result in increased services to migrants, it would in actuality only divide the allotment among more programs. Present Title XX funding is already insufficient due to the fact that from 1973 to 1975 there was a 9% increase in funding while the inflation rate was 14%. Money from line items is currently distributed to area offices which then allocate it to their various programs. To obtain a line item for migrants, DCFS would have to assess the need and then establish it legislatively in the budget.

Education

The Title I Migrant Education program is the sole provider of education to school-aged migrant children with the exception of about 100 children who are served by the regular Title I program. The Migrant Student Record Transfer System indicates that 2,221 migrant students between the ages of 6 and 18 are enrolled in Illinois. The summer program runs 8 to 12 weeks depending on the school districts' schedules. Local districts have a great deal of autonomy in tailoring the program to meet local needs. Hours of operation are determined by Title I Migrant personnel and are structured to correspond to the working hours of the parents. In some areas classes are held from noon to 4:00 p.m. or from 5:00 p.m. to 7:00 p.m. If classes coincide with the regular school day, they usually end at 3:00 or 3:30 p.m. Migrant programs in the Chicago area operate from 8:00 a.m. to 5:00 p.m., thus providing after-school care. The state Title I director feels that generally a program running from 8:00 a.m. to 5:00 p.m. creates too long a day for migrant children. Most migrant parents go to work early but are usually home by mid-afternoon, and thus late-afternoon classes are not necessary in many cases. The number of migrant children remaining for a portion of the school year program varies with the area, but classes are provided in the late fall and early spring as needed.

There are no priorities in the ages served, but there are more children in school between the ages of five and eleven, so the program is geared to grades one through six. The statewide curriculum concentrates on reading, mathematics, and language arts, and includes supplemental and enrichment programs and activities. Local directors develop the programs according to the resources available. Generally, the facilities are excellent. Some of the schools have swimming pools for use in the summer program.

Although the number of former migrant staff members is not known, there are about 100 Mexican Americans involved in the program. Identification and enrollment of migrant children are done by eighteen bilingual aides.

The MSRTS on which children are enrolled is reportedly just beginning to function effectively. Presently, Illinois is utilizing the system fully, aided by an increase in allocations for the MSRTS. Information from Texas schools is often not entered on the MSRTS. The Illinois director talked with school offícals in Texas in an effort to improve this situation.

In Illinois, a well-directed effort is still necessary to encourage local schools to apply for money for Title I Migrant programs. The approach is individualized to the school. The principals are involved in meetings in which the advantages of the program are delineated.

Although the summer programs are basically planned before migrants arrive each season, settled-out migrants and aides help to plan at the local level. The programs are flexible and are modified by suggestions from parents. Most of the local programs have been functioning for several years and each is unique. Program planning at the state level includes the local directors and, in some cases, teachers and aides who are former migrants. The Title I Migrant Advisory Council assists in program planning and has two Spanish-speaking members and one grower on its staff. The state director feels that he is familiar with the problems of his students as both of his parents were migrants.

Title I Migrant staff members stated that their program provides leadership to the other programs which serve migrants. The first migrant health program was written by the state Title I director. Illinois Title I Migrant also published a bilingual directory of services to migrants with explanations of each service and their locations throughout the state. Title I Migrant staff members meet formally with the Department of Children and Family Services and with the migrant council at Regional Council Meetings. They also maintain informal contact with other agencies. DCFS is provided with the use of MSRTS for the purpose of enrolling preschool children. There was some criticism of the migrant council for not projecting long-range goals for migrants. This was tempered somewhat by a suggestion that the Department of Labor is greatly influenced by large corporations which makes it difficult for the migrant council to work in the migrants' interest and also satisfy DOL.

The state director of Title I Migrant Education has recommended that a State Bureau of Migrants be established. He feels, however, that a Bureau of Migrants would have to be instituted at the federal level first. The existence of such a bureau would give the state Migrant Affairs Coordinator sufficient power to bring about coordination among service agencies.

As mentioned, there are regular statewide planning and evaluation meetings with the local directors of migrant education programs. The Title I region which encompasses Illinois also works very successfully with a great deal of cooperation among the states.

The effectiveness of the program is enhanced by openness with the national director of Title I Migrant programs, which is highly valued by the state director. Support from the Illinois Office of Education was felt to be another critical factor in the success of migrant education programs in Illinois.

Problems in service delivery have been largely overcome due to the efforts of the staff persons. Many local objections to the operation of a Title I Migrant program have been overcome. The Title I Migrant program itself seems to be flexible, well-adapted to local political realities, and well-coordinated.

Health

The Illinois Migrant Council is the major provider of health services to migrants throughout the state. The migrant council administers three clinics directly and contracts out two clinics. The three clinics administered directly are in Rochelle (Ogle County), Hoopeston (Vermillion County), and Chicago Heights (Cook County). A migrant health coordinator in the central IMC office provides the administration for these projects, including grant administration and project coordination. Individual projects are thus free to concentrate on service delivery. The main source of funding for the projects comes from the Migrant Health Act, with funds from WIC contributing the other major portion of funds. These funds are supplemented by some state money and a small amount of mental health funds which are just beginning to be used.

The clinics are located in populous migrant areas and maintain evening hours for maximum accessibility. A total of 2,000 children were screened through Title I Migrant Education programs. The clinics offer immunizations, home health and outreach, health education, pediatric care, physical examinations and screening, and the WIC program at all locations. Dental care is provided by the clinics for Title I students, also, and some clinics have pediatricians on staff. Providing for hospitalization of migrants is difficult. In some cases, migrants are eligible for partial hospitalization coverage under township laws. When these laws are not applicable, the responsibility for payment for in-patient care is not clear.

The most common illnesses observed in children were upper respiratory infections, gastro-intestinal problems, and parasites. Although there is a shortage of bilingual registered nurses, more than half of the staff at the migrant clinics is bilingual and most of these staff members are former migrants.

Outreach is supplied at each clinic by clinic personnel to ensure that the availability of services is known. The health records of school children are entered on the MSRTS and are therefore accessible to any health care provider. Preschool children are not yet entered on the MSRTS.

The migrant health coordinator maintains adequate informal coordination with Title I Migrant Education on the state level. Locally, all the clinics work closely with school program personnel. A linkage with the State Public Health Department furnishes a consultant pediatrician from the Division of Family Health. This pediatrician is also a member of the governing board of the migrant council. Although there were no formal interagency meetings, the health coordinator felt the informal contact was sufficient to facilitate service delivery.

Staff development is provided for all clinic personnel through bimonthly meetings and regular workshops. Currently, there are no research projects on migrant health.

Despite the assets of the IMC health program, many problems are encountered in service delivery. Several of these are directly attributable to inadequate funding. Present reimbursement to physicians for services is insufficient to attract the number of physicians needed. The lack of adequate funding of the migrant clinics necessitated a fee scale which prohibited some day care centers from using the clinics for children's physicals. Payment for hospitalization is not clearly the responsibility of any agency and no agency has sufficient funds to cover the charges.

According to the migrant health coordinator, the nonresident status of migrants makes them ineligible for certain Illinois programs under which they could otherwise receive services. These programs are Title XIX (Medicaid) and Title V (Maternal and Infant Care). An additional administrative problem discussed was the great amount of time necessary for grant administration. Grant applications must be completed yearly, and it was suggested that long-term planning and funding would allow more efficient administration of grants.

Migrants may also be recipients of health care provided directly or indirectly by the Public Health Department. The only services targeted for migrant farmworkers are the WIC program and dental care. The WIC program is administered by the Illinois Migrant Council and served 1,519 children statewide. Dental care was provided for 25 children who did not receive care through Title I. According to the consulting pediatrician, direct or indirect services "may include migrants and may not preclude them from becoming beneficiaries." Such services include immunizations, venereal disease investigation and referral, vision and hearing screening programs for preschool and school-aged children, perinatal programs, family planning, dental care, and maternal and infant care. Although the state has no different eligibility requirements for migrants, local health departments are independent and may impose restrictions on eligibility.

The consultant pediatrician to the IMC represents the migrants' interest in the State Public Health Department. He attended a conference on Child Abuse and Neglect in 1976 and is initiating a research project on the WIC program. From his vantage point, the consultant felt that follow-up and referral in migrant health programs could more easily be achieved under the auspices of an agency with greater capability for providing administrative services.

CHAPTER V

IOWA: MUSCATINE COUNTY

There are about 5,000 migrants and seasonal farmworkers in Iowa. Over 90% of the migrant farmworkers in Iowa are Spanish-speaking and of Mexican American background. Most of these farmworkers have their home base in the southern Texas Valley area along the Mexican border. They occasionally find farmwork in Texas during the winter and leave for Iowa in early spring as part of the mid-continent stream.

The farmworker organization reported that there were twice as many migrants in Iowa in April 1977 as in any other spring in any of the previous 13 years, arriving while snow was still on the ground. Migrants traveling in the mid-continent stream seldom move as far into the mid-west as Iowa, but when the frosts hit the Florida citrus groves, many farm laborers were forced to find work elsewhere. While the mid-western drought creates uncertain labor demand, conditions such as demographic shifts and 1977's unfavorable weather result in much greater need for services to migrants.

The bulk of the migrant population in Iowa is concentrated in Muscatine County, located in the southeast quadrant of the state bordering central western Illinois. Relative to other Iowa counties where migrant labor is utilized, Muscatine County has a long farmwork season which lasts from May to September. The major crop harvest in Muscatine County is tomatoes, but migrant labor is also used in cultivating cantaloupes, melons, and potatoes.

Services and Needs in Muscatine County

Social Services

The Department of Social Services (DSS) offers a full range of social services in Muscatine County. Eligibility for social services is established by presenting a birth certificate or visa. This criterion applies equally to migrants and nonmigrants, and DSS staff members estimate that less than one percent of all applicants are undocumented workers. The agency does not maintain records on migrants as a sub-population. The DSS staff includes three bilingual persons, one a former migrant. One of the three bilingual staff persons is assigned to handle food stamps; another is a former migrant employed as an income maintenance worker; and the social service worker is responsible for social services to migrant families, particularly during the peak season.

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The presence of these bilingual people on the staff has facilitated service delivery to migrants because it has made other service agencies more willing to refer migrants to DSS. This has led to a gradual increase in the number of migrant clients who utilize the DSS.

Services offered by the DSS include the standard social services and interstate and intrastate referral to ensure continuity of service. Employees indicated that, in 1975-76, one migrant child was provided with foster family care, 10 migrant children received protective services, 15 were provided with social services in their own homes, 50 received family planning services, and 60 Aid to Dependent Children (ADC) clients were provided with Medicaid EPSDT services. Staff members indicated that settled-out migrants comprise 8% of the ADC caseload.

A five-member board oversees the activities of the DSS. DSS staff members have not participated in staff training nor are they engaged in program development activities related to migrant child welfare. There is little coordination between the DSS and other service provider agencies.

A deterrent to service delivery is the absence of outreach programs in the DSS. Outreach activities are, of course, criticial to making social services available to migrant farmworker families. Since language barriers are no longer a hindrance to migrant DSS clients, outreach activities and greater coordination with other service providers could greatly increase the number of migrants served by DSS.

DSS staff members indicate that there are other problems which affect service delivery to migrants. Transportation problems make it difficult for migrants to get to the DSS offices for services. DSS personnel pointed out that, in the past, migrant families have felt fearful and distrustful of protective services caseworkers. As a result, the DSS focuses on in-home treatment in cases of child neglect and abuse, making every effort to avoid the use of other institutional resources, such as the police. To expand services to migrants will require other service providers to continue to increase referrals to DSS. The DSS hopes to improve the ability of its staff to assist migrants. The recent addition of a bilingual social worker represents a step forward, and DSS is currently trying to recruit a bilingual homemaker for in-home treatment. Also, the DSS is working to recruit Spanish-speaking people to provide foster homes. This would make it possible to expand DSS foster home services for migrant children. There are indications that a contributing factor in problems of social service delivery to migrants is the generally unreceptive attitude of the Muscatine County government toward migrant farmworkers. County governments are responsible for providing 5% of the matching funds for Title XX programs.

A local level service agency, the Voluntary Action Organization, does not provide services to migrants. Thus, DSS and Migrant Action Program, the farmworker organization, cover the provision of social services in Muscatine County.

Child Care

In Muscatine County, the major provider of day care and Head Start programs is the local division of the Migrant Action Program, Inc. (MAP), the statewide farmworker organization. This agency contracts out a portion of its services. The County Department of Social Services plays no role in providing day care for migrant children. The programs run by MAP provide day care and educational activities for infants and toddlers. Preschool youngsters participate in a Head Start program. Support services of the Head Start program include health care, transportation, and three meals a day. The children under age four who participate in the day care program are provided with food under a $6,000 USDA grant. MAP hires people to provide day care at migrant camps and sends mobile units to isolated camps to offer educational programs. During the peak season, the day care and Head Start programs serve an average of 75 children ranging in age from less than one year to nine years. An average of 60 children are served during the rest of the year. The minimum age for acceptance into the day care program is two weeks, and day care programs are run during double shifts, with the result that the children are supervised during the full working hours of their parents. Muscatine County is the only Iowa county in which MAP operates day care on a double shift basis. Child care services are available on weekdays only. It is estimated that the MAP-sponsored programs meet the child care needs of approximately 60% of the migrant child population in Muscatine County.

The MAP Head Start program maintains contact with the State Health Department, the Muscatine Migrant Committee, and migrant camp owners. In 1975, MAP derived its funding for day care from the Iowa State Department of Social Services ($33,500) and a community action agency, Iowa East Central TRAIN ($4,125). The MAP Summer Head Start program was supported in 1975 by the Department of Health, Education, and Welfare, Office of Child Development ($57,000), and the Iowa State Department of Public Instruction ($3,500).

Several problems were identified by MAP personnel operating day care and Head Start programs. There is a need to increase the capacity of child care programs in order to serve children who do not presently participate. One difficulty in expanding programs is that of finding space for day care and Head Start facilities. MAP has unsuccessfully approached representatives of local schools and churches. Finally, one church made its space available for day care, but only after resolving an internal division over the issue. There is only one Head Start facility, and some of the students must travel more than two hours in order to participate in the program. Although transportation is provided, the need for additional centers is crucial. Also, the present transportation arrangements are inadequate for accommodating the day care children without overcrowding; another vehicle is needed. Program employees indicate that coordination with the parents of students needs to be improved. Increased parental involvement is desirable to enable parents to provide continuity between the educational program and home life.

The Muscatine Community College Child Care Center began to provide day care for migrants in the late summer of 1976. This Center serves children ages three to five, and includes nine migrant children in its day care program. The Center is forming an advisory board which will include migrants as members. Other than one cook, there are no Spanish-speaking persons among the Center personnel at present. MAP provides transportation to and from the Center for the migrant children served there.

In brief, the major problems affecting child care programs in Muscatine County are the lack of facilities and transportation difficulties. Of course, the primary issue in terms of migrant child welfare is that the child care programs are unable to accommodate all the children who need such care.

Education

Muscatine County has had a migrant education program since 1965 which has been funded through Title I since 1967. At present, the program is one of three migrant education programs in Iowa. The local schools in Muscatine County operate Title I Migrant programs which provide special educational services for migrant children in the summer and during the school year. The educational services provided exclusively for migrants include individualized and bilingual instruction, language development, and a bicultural program.

During the academic year, the Title I Migrant program serves 61 migrant children in six elementary schools and one junior high school. Two high school students are among those served. The staff consists of three instructors and one teacher's aide who provide supplemental instruction to migrant students. In September 1975, a language development program was initiated in Muscatine County schools as part of the Title I Migrant program. This program was designed to serve Mexican American migrant children. It stresses the assessment of reading and language levels of students and oral language instruction at the early primary and junior high levels. The program is also intended to foster positive attitudes toward self and school, and to encourage pride in the Spanish language and Hispanic culture and respect for other cultures. A number of support services are offered as part of the migrant education programs. During the academic year, psychological counseling and social work services are provided as required. Five bilingual instructors operate the bicultural program in six elementary schools and one junior high school. During its first year the bicultural program met with moderate success in the view of school officials. The schools now plan to initiate similar programs for kindergarten and first grade students because it is believed that migrant students' unique educational needs must be met at an early age.

The Title I Migrant summer program runs for six weeks, from early July through mid-August. Summer program funds were reduced from $39,000 in 1974 to $31,965 in 1975. This program provides English as a Second

Language and operates at one school, serving 111 migrant children. Support services for the summer program are more extensive than for academic-year programs, with all children provided USDA-funded breakfasts and counseling services; 80% of the students receive health diagnosis and are covered by accident insurance, and about 6% of the students receive health treatment. A few standard support services are not included in Title I Migrant programs in Muscatine County. There are no provisions for outreach to recruit students; MAP takes the responsibility now. Because the migrant education programs in Muscatine County do not serve secondary school students, vocational and career counseling are not available.

Muscatine County schools utilize the MSRTS, and staff members report that the system functions well in providing health information on migrant students. The MSRTS data on education was described as "inconclusive" and "not beneficial" for purposes of monitoring or facilitating continued educational progress among migrant students. Often, records received did not contain information from schools attended previously by migrant children. It was suggested that information relating to basic instructional objectives be recorded on the MSRTS and that schools be urged to update such information.

The Muscatine County schools report few problems in the operation of Title I Migrant programs. Later evaluations may be more revealing since the LEA did not administer Title I Migrant programs during the academic year until 1975, and the bilingual/bicultural program was initiated in 1975.

Health

The major provider of health services to migrants in Muscatine County is the Muscatine Migrant Committee (MMC). This organization operates a clinic in Muscatine which serves some 1600 migrants and 400 settled-out migrants in a five-county area in Iowa and Illinois. An unusual feature of the MMC program is that it emphasizes preventive health care and provides comprehensive health services which include dental care and health education. In 1976, MMC was financed by a $82,000 grant from HEW and contributions from United Way and local donors.

MCC offers the following services at no cost to migrants and to settled-out migrants: pediatric care, obstetrical-gynecological treatment, general medical care and dental check-ups, family planning, nutritional education, immunizations, tuberculosis tests, counseling, simple laboratory procedures, and a pharmacy. It is rare for a migrant health program to operate a pharmacy and provide medicines at no charge. In addition, the MMC provides an exceptionally broad range of health care services to migrants. A 1975 census indicated that MMC health care services reach virtually all migrant children in Muscatine County. Recently, MMC began operating a WIC program. Since MMC is the sole provider of WIC in Muscatine County, it serves nonmigrants as well as migrants in this program. A WIC coordinator is on the clinic staff. Migrants are referred to doctors, hospitals, or whichever appropriate provider is required for services that cannot be provided by the MMC. Referral services are available for all MMC clients. Pediatric referrals are made separately from other referrals so that the specific health needs of migrant children can be adequately addressed. Migrants may also be referred for hospitalization since in-patient care is financed by the state. Planned Parenthood cooperates with MMC in helping arrange hospitalization for delivery. A number of support services are provided by the clinic. MMC transports migrants to its clinic and provides transportation and interpreter services in cases of referrals. Educational films on health and nutrition and recreational films are shown in waiting rooms of the clinic. This type of service is provided only rarely by migrant health programs.

Virtually all of the staff members of MMC are settled-out migrants and are bilingual. Service delivery is, therefore, facilitated as about 99% of the clients are Chicanos. Most staff members at the clinic are volunteers. The personnel includes nutrition and pharmacology students, senior medical students, dental students, and migrant public health nurses. The medical students are supervised by a physician. Follow-up health care is provided through subsequent visits to the clinic and home visits made by MMC nurses. The nurses also provide outreach services by making three or more visits annually to each labor camp, at which time they inform camp owners and migrants of MMC services and record health histories of the migrant families.

The 16-member Board of Directors of MMC includes eight migrants and former migrants and four growers. MMC program management activities include coordination with a variety of agencies and individuals with the dual purpose of avoiding duplication of services and upgrading health services to migrants. Comprehensive health service delivery is provided to migrants and settled-out migrants through coordination between MMC and the State Health Department, Planned Parenthood, County Medical Association, and the Community Nursing Association. MMC provides physical examinations and immunizations to students participating in the Title I Migrant programs at the local schools and refers migrants to DSS. MMC exchanges information frequently with MAP.

Staff training is an ongoing effort within MMC programs. An interagency orientation is offered each year for the entire MMC programs. This orientation describes the services of various public and private agencies in Muscatine to which migrants may be referred. MMC conducts an in-service training for all persons hired to work with the program in the summer. In addition, staff members have been sent to training sessions sponsored by other organizations. The project nurse attended a Migrant Referral Conference that described the methods of ensuring continuity in health care for migrants. The project director and nurse participated in a five-day seminar on environmental sanitation. MMC conducts research related to health service delivery in the form of an annual census which also functions as an outreach activity because the census-takers inform migrants of MMC health services in the course of their interviews. The efforts made in staff training and research by the MMC are unusual and point to a comprehensive view of health care and service delivery. Very few health programs are involved to such a great extent in staff training and research projects.

The major problems encountered by MMC in providing health care to migrants are lack of funds and lack of qualified staff persons. In 1976, MMC ran out of money. The agency was provided with a small allotment of supplemental funds from MAP, but services were, of necessity, curtailed. At present, the agency is trying to locate a family practice resident physician for its staff. Since the clientele of MMC is Spanish-speaking and of Hispanic descent, there is a need to find and employ trained bilingual people, and especially those of Hispanic background. Staff members indicate that it is important for Hispanic people to have opportunities to become trained as health professionals. MMC expects to have ongoing difficulties with financial support as a funding cut is anticipated this year. Despite these difficulties, the MMC health care program is notable for the comprehensive nature of its health care services and the degree to which it is engaged in related activities, such as operation of a pharmacy, extensive outreach services, research, and training. The program appears to be well conceived and well implemented.

There is no county health department in Muscatine County. There are, however, organizations which supplement the services of the MMC. The County Medical Association is an organization of doctors with a referral service, and MMC refers clients to them when necessary. The Community Nursing Association provides immunization to settled-out migrants. Health System Agents of the Department of Health, Education and Welfare are in Muscatine County and coordinate HEW-funded efforts in health care. MMC draws on the resources of these organizations in providing health services to migrants.

Farmworker Organization

Migrant Action Program, Inc. (MAP), is the statewide farmworker organization authorized to represent migrant farm labor in Iowa. MAP has been in operation since 1964 and presently has five area offices. In order to utilize MAP programs, a person must be residing in Iowa, be a citizen or legal alien, and have earned at least 51% of his or her income in agricultural work. Approximately five percent of MAP applicants are ruled ineligible on the citizenship criterion, and about 20% are disqualified because less than half of their income is derived from farmwork. The primary function of MAP is to provide manpower training and related services for migrants seeking to settle out of the migrant stream. In 1975, the MAP manpower unit served 1900 migrants and 100 seasonal farmworkers, and 46% of MAP's $500,000 budget was devoted to this effort. In addition, MAP provides a wide variety of services including health care, children's programs, food and nutritional services, legal aid, and emergency assistance. Children's programs include day care for infants and toddlers, Head Start, and Title I Migrant Education.

Twenty percent of the MAP budget for 1975 was allocated to administer these programs and supportive services. The MAP child care problems are described below in the day care section of "State Service Provider Agencies."

MAP is involved in a number of activities directed toward promoting the welfare of migrant children and of migrants in general. The organization makes presentations at conferences and to social service agencies, church and civic organizations. MAP has produced a videotape showing the needs and problems of migrants in Iowa. In Muscatine, a videotape was made of the activities in the day care center, and this has been shown to social service agencies in Mason City. MAP publishes an annual report, widely distributed around the state, which describes its programs and the needs of migrants.

In assessing migrant child welfare services, MAP staff members stated that welfare needs of migrant children are not fully met. They indicated that migrant children do not receive adequate services in health, nutrition, or education. The farmworker organization employees identified a number of problems which have an adverse effect on migrant child welfare in Iowa. Statewide, 80% or 90% of migrant children under 14 work in the fields and, thus, available services are inaccessible to them. MAP employees also feel that child labor laws should be enforced in order to alleviate this situation. It was suggested that services be brought to these children through the use of mobile classrooms and mobile clinics. Staff workers in Muscatine and at the MAP state offices in Mason City indicated that state and local service providers discriminate against migrant children, and that children have been denied services. They propose that the problem be attacked by having MAP participate on the policy-making boards of other service providers and by making the federal government aware of the problem so that it will monitor state and local programs and require those governments to enforce anti-discrimination laws. MAP has experienced difficulty in gaining the cooperation of state level social service agencies in delivery of services to migrants. Also, state agencies lack the funds and resources necessary to address adequately the needs of migrants. Local level social service providers have poorly trained personnel. These problems could be resolve with more money and resources, by recruiting bilingual people for social service agencies, and by offering better salaries to attract qualified people to work with social service agencies.

State Service Provider Agencies

Social Services

Statewide, the Iowa Department of Social Services provides a full range of social services except for in-home treatment and administrative support. Services are planned and delivered at the district level; each district encompasses two or more counties, and there are 16 districts statewide. Participants in Aid to Dependent Children and Supplemental Security Income programs and those who meet income criteria are eligible for services. In addition, certain services, such as protective services, mental health care, and the like, are provided without regard to eligibility. Service delivery may be direct or through purchase from public or private providers. As of July 1, 1976, the DSS budget was using 100% of the federal portion of Title XX budget. Funding for social services is derived from the federal government (75%), state government (20%), and county governments (5%).

DSS records do not identify migrants as a subpopulation. There is, however, some information about services provided to migrants by the DSS. Caseworkers indicate that in fiscal year 1976 DSS provided protective services to 12 migrant children, social services for families under stress, and home management services to two migrant children. Through a contract with the farmworker organization, DSS provides day care to 101 migrant children of working parents. The budget for this program was $43,862 in 1975 and $40,789 in 1976. These allocations represent the only DSS expenditures made exclusively for migrant children.

State DSS officials report that it is impossible to determine how many of their staff persons are bilingual. There is one Spanish-speaking summer employee in Muscatine County. The protective services division produces Spanish-language tape recordings and news articles to inform Hispanic people of its services. There is at least one former migrant on the DSS staff who works determining the eligibility of ADC applicants. DSS has no staff persons assigned specifically to address the welfare needs of migrants or migrant children. Outreach functions are handled primarily by MAP.

DSS coordinates with the farmworker organization by maintaining active liaison through meetings and by utilizing the resources of both organizations to meet the needs of clients of each agency. There are DSS advisory committees at the state and local levels. Each of the 16 districts has a Title XX Planning Committee which determines the allocation of state monies to programs. The State Social Services Board approves DSS policy. DSS staff members are not involved in staff training or research projects related to migrant child welfare services.

Little information was obtained about needs or problems with Title XX services in Iowa. Protective services administrators indicated that the federal government should continue to have the major responsibility for delivery of welfare services to migrant children because local governments are not sufficiently committed to providing services to migrant children.

A statewide voluntary organization, Lutheran Social Service of Iowa, provides various welfare services throughout the state. The programs of this organization, however, do not serve migrant children. In Reinbeck, the local Council of Churches has included migrants in community gatherings and made donations of clothing and other essentials to migrants.

Child Care

There are two providers of day care to migrant children in Iowa: Migrant Action Program and the Muscatine Community College Child Care Center. Migrant Action Program, Inc. is the major provider of day care and Head Start to migrant children in Iowa. In 1975, MAP served about 230 children, ranging in age from two weeks to five years. The funding sources for these programs were HEW (Head Start and Head Start-Handicapped), DOL (CETA-303), and Iowa DSS.

Day care services are concentrated in Mason City and Muscatine where MAP operates licensed day care centers and a bilingual summer Head Start program. In Mason City, approximately 120 infants, toddlers, and children under five participate in day care and Head Start programs, and in Muscatine about 75 children participate in similar programs. The curriculum at these centers includes basic skill and career development exploration areas, standard preschool activities, and field trips. In Mason City, the children also receive swimming lessons at the YWCA. In Muscatine, the hours of day care are extended to match the working hours of migrant parents. MAP day care and Head Start centers are funded by $66,000 from Iowa DSS and $45,000 from Migrant Head Start. CETA monies are also utilized by MAP to provide day care to an additional 40 children. Slots are purchased in licensed facilities to serve about 34 migrant children who live in three rural communities. MAP also hires people to provide day care in labor camps for a small number of migrant children in another community.

All migrant children participating in day care and Head Start programs receive three meals a day, health diagnosis and treatment, immunizations, Medicaid EPSDT, health education, and dental care. A registered nurse is assigned to work with children's programs and children have been referred to the Area Education Agency for audio screening and to doctors for dental screening, physical examinations, audio follow-ups, and treatment of specialized problems.

The MAP staff for children's programs totals 28 and includes 7 former migrants and 9 migrants who work as teachers and teacher's aides. Outreach to migrant families is provided as part of the overall service program of MAP. Training has been provided to some child care staff members who have attended seminars on policy and mental health.

The Muscatine Community College Child Care Center also provides day care to nine migrant children, ages three to five. This facility first began to include migrants in its programs in late summer of 1976. The Center will include migrants as members on its advisory board. MAP coordinates with the Center by providing transportation for migrant children who participate in the day care program.

The Iowa DSS provides day care to children throughout the state with Title XX funds. Funding provided by the agency to MAP day care programs represents the only day care service provided by DSS to migrant children.

Education

Title I Migrant education programs operate at seven schools in two districts in Iowa on a year-round basis. Migrants are enrolled in these programs throughout the school year and for six weeks in the summer, from early July through mid-August. Major centers of migrant education programs are Muscatine, Reinbeck, and West Liberty. In these communities, educational programs oriented to the special needs of migrants predated the inception of Title I Migrant programs, and were offered by migrant organizations and teachers working on a volunteer basis. Summer programs offer a curriculum covering English as a Second Language and basic skills. Summer programs run from 8:30 a.m. to 3:30 or 4:30 p.m., and it was reported that these hours do not coincide with working hours of migrant parents. Programs offered during the academic year focus on development of reading and language skills in English, on mathematics and on basic skills. Title I Migrant programs are open to all school-age children; there is no priority by age. Summer programs generally concentrate on serving elementary school students, since older children are usually working in the fields. Title I Migrant education serves preschoolers through a contract with MAP.

A number of supportive services are provided to students enrolled in Title I Migrant programs. The West Liberty program includes a bilingual classroom and special instructional materials. All of the migrant students are provided with free breakfasts, health screening, MSRTS, accident insurance, career counseling at the secondary level, counseling services, and transportation. State officials estimate that over 90% of migrant students are provided with health treatment, outreach services, and summer programs. About half of the Title I Migrant students receive dental care, and about 5% receive psychological counseling or participate in a vocational program. These additional services are funded by Title I Migrant, the Office of Child Development of HEW, U.S. Department of Agriculture, Iowa Public Health grants, Iowa DSS, and local educational agencies. The farmworker organization cooperates with the local DSS offices to provide outreach services. The state Title I Migrant budget for 1975-76 was $99,306.

An unusual aspect of migrant education in Iowa is that the state legislature has devoted attention to the program by appropriating funds, "for education aid to physically and mentally handicapped children, and to migratory children of migratory workers." These funds have been divided equally between elementary and secondary school migrant education programs and adult migrant education programs. Local educational agencies are charged with the responsibility of identifying needs, proposing programs, and gaining the cooperation of other service agencies in the area of migrant education.

State Title I Migrant officials report that 354 migrant children were served in the 1975-76 academic year. Estimates based on Title I Migrant enrollment figures indicate that between 50 and 70 migrant children of school age are not served by Title I Migrant programs in Iowa. All migrant students are enrolled on the MSRTS. State Title I

Migrant officials report that the MSRTS is not very effective for academic records, but the type of information received is improving. Muscatine school officials indicated that the MSRTS works effectively for monitoring the health status of migrant students. Title I Migrant staff at LEAs have attended workshops explaining the functioning and utilization of MSRTS.

Statewide, the Title I Migrant staff totals 32 persons. There are six teachers and seven teacher's aides who are migrants or former migrants. The number of bilingual personnel in migrant education programs is not known, but there are at least 10 bilinguals on the staff statewide. The state Title I Migrant staff works jointly with MAP and Iowa DSS to recruit eligible migrant students into its programs. It was reported that all eligible school districts have applied for Title I Migrant funding. LEA officials are involved, however, in promoting increased interaction among teachers, school officials, and migrant parents.

Migrant parents do have a role in Title I Migrant programs. Parents do not participate in planning summer programs since most of the planning is completed before they arrive in Iowa. Settled-out migrants, however, are encouraged to participate in program planning. Parent Advisory Councils are involved in evaluating the effectiveness of Title I Migrant programs. At the local level, schools are working to increase the involvement of migrant parents by recruiting migrants to serve as homeroom mothers and by encouraging teachers to visit migrant camps. There are few other program management activities for migrant education. Coordination with other state departments working with migrant children is informal.

State officials identified several problems that affect the operation of Title I Migrant programs. School hours during the summer do not correspond to the working hours of migrant parents and, as a result, children are left unsupervised during part of the day. The contribution of migrants to the planning and operation of migrant education is limited due to the mobility of migrants and to the planning schedule. MAP personnel who coordinate with the Title I Migrant program reported that, during the academic year, children of settled-out migrants often do not receive the supplemental educational services to which they are entitled. Settled-out migrants are dispersed, and often live in school districts which do not provide Title I Migrant services. Coordination between LEAs is poor, so educational services to migrant children of settled-outs are generally inadequate. Another problem was that the Title I Migrant summer program was unable to provide adequate services to three emotionally disturbed migrant children. Had these children been participating in a school-year program, psychological evaluations and counseling could have been provided through the standard supportive services available at the schools. Either a lack of funding or inflexibility in the funding provisions for state summer programs made it impossible to provide psychological attention with Title I Migrant monies. The three students were finally provided with psychological evaluations and some counseling through Office of Child Development funding. This incident points to the problems which are created when unanticipated needs arise and the existing structures cannot provide for those needs.

Despite these difficulties, it is felt that the Title I Migrant programs are functioning quite effectively and reach the majority of migrant students in the state. Migrant education staff suggested that a person be employed full time to coordinate the diverse programs serving migrant children so that a comprehensive service plan could be provided to meet the needs of migrant children.

Health

The Migrant Health Project (MHP) of MAP and the Muscatine Migrant Committee are the two providers of health care to migrants in Iowa. These two programs offer primary health care, referrals, health education, and outreach services. The geographical service areas of these programs are different but, taken together, the two programs provide health services to migrants throughout the state.

The Migrant Health Project (MHP) of MAP is the primary provider of health care to migrants in Iowa. The Project offers primary health care and comprehensive medical and dental treatment to eligible farmworkers in 96 counties of Iowa. The services offered include immunizations, physical examinations, emergency care, screenings, hospitalization, referrals, outreach, follow-up, health education, and camp inspections. Most of the services are centralized in the MAP Mason City headquarters and in other field offices. A major component of service delivery is nursing visitations made to day care centers, schools, and migrant camps.

In 1975, MHP saw 615 patients for a total of 2,022 visits. Project services focus heavily on meeting the health care needs of migrant children. Immunizations were provided to 118 children; 86 children received complete physicals; and dental and preschool medical clinics served about 100 children. All children in MAP day care and Head Start programs receive laboratory tests and audio-visual screening. Services provided through MHP referrals to specialized health care providers are paid for by MAP on a fee-for-service basis. The MHP staff consists of one full-time nurse, four part-time nurses, one physician's assistant, and one bilingual aide. MHP outreach activities are extensive; regular nursing visits are made to all migrant camps and other farmworker residences, and daily visits are made to day care and Head Start centers. In addition, MHP staff accompany Iowa State Department of Health officials on inspection visits to migrant camps and provide follow-up to ensure that violations are corrected. Continuity of service is facilitated by MHP staff who utilize the National Migrant Health Referral Project to refer migrant children in need of follow-up care to health care providers in other areas. The health education program focuses on teaching preventive health care in the areas of nutrition, dental and child care, family planning, sanitation, and personal hygiene.

Program management activities for the Migrant Health Project involve contracts and coordination with a number of private and public health care providers and service agencies. MHP contracts with more than 35 pharmacies and 15 hospitals. Migrants are referred to 75 doctors, 20 dentists, and a number of other specialists. Formal linkages are maintained with the Iowa DSS, State Department of Health, private health associations, church and civic groups, etc., which provide consultations and supportive services, including donations of medical supplies.

The Muscatine Migrant Committee is the other major provider of health care to migrants in Iowa. MMC serves farmworkers in Cedar, Louisa, and Muscatine Counties--the three counties not served by the MHP. MMC also serves migrants in two Illinois counties. Preventive and comprehensive health care, including dental care, a WIC program, and health education, are provided by MMC. The agency offers a number of supportive services, such as general, pediatric, and hospitalization referrals, and provides transportation to its clinics and in referrals. Virtually all of the MMC personnel are bilingual and are former migrants. Outreach is provided through regular nursing visits to migrant camps.

Program management activities center around coordination with other health care providers--the State Department of Health, Planned Parenthood, county medical and nursing associations, etc.--to ensure the delivery of comprehensive health care to migrants. Staff training is provided by MMC, and personnel are sent to training sessions offered by other organizations. A census of migrants' health care needs is conducted annually by MMC. A full description of MMC health care services is provided in the health section of "Services and Needs," above.

The State Department of Health does not provide health services to migrants or migrant children. The department, however, has provided Spanish-language health literature and some medical supplies to support MHP and MMC health programs.

CHAPTER VI

MARYLAND

Maryland was selected as the state in which the data collection techniques would be pretested. As a result, information about Maryland is not entirely comparable with information gathered from the other eleven states, and direct comparisons may not be possible. There are two reasons for this. First, the data collection instruments used in Maryland were draft instruments; following their pretest applications, final forms were developed and used in the remaining states. These sometimes differed substantially from the pretest forms. (See Appendix) Second, four counties in Maryland were visited, rather than the one county with the largest migrant population as in other states. After the Maryland pretest was completed, the decision to visit only one county per state was made for the purpose of producing more comprehensive data. Therefore, the area encompassed by the Maryland study is larger and less intensive than that examined in the other states. The overall effect of these differences makes the nature of the Maryland data somewhat different than the data collected in the other 11 states. Nevertheless, the information on Maryland is presented here because this information provides useful additional information.

Most migrants in Maryland live and work on the "Eastern Shore," the portion of the state east of the Chesapeake Bay. Four counties on the Eastern Shore were studied: Wicomico, Talbot, Somerset, and Worcester. The principal crops in these counties are tomatoes, cucumbers, asparagus, and sweet potatoes. The presence of migrant farmworkers in Maryland is a fairly recent phenomenon, and most migrants, remaining isolated from the local communities, are relatively invisible. The presence of the migrant population seems to be unrecognized by many agencies.

Services and Needs in Somerset, Talbot, Wiconomico, and Worcester Counties

Information on services and needs in Maryland was gathered in several counties, and is not available for all counties equally. Thus, the following picture is not necessarily as complete as the other states and it is possible that some service providers may have been overlooked.

Social Services

Worcester County

The Worcester County Department of Human Resources provides foster care, emergency shelter, hospitalization, food stamps and family planning services. However, migrants experience difficulty in obtaining these services. For instance, most migrants are not eligible for food stamps, either because the camps have communal (rather than individual) cooking facilities, or because they are not able to obtain evidence of their earnings from the crew leader. Hospitalization can be paid for by Medicaid, but this requires county residence, and migrants are generally not in the area long enough to establish residence. A local, council of agency representatives meets to focus on special service needs. However, the council does not meet during July and August, the time of peak migrant activity and local politics and insufficient funding make it unlikely that the needs of migrants will be addressed in the near future.

Somerset County

The Somerset County Department of Human Resources provides services to all who request and need them, including migrants. The DHR records do not identify migrants by classification, but this can usually be determined by the address of the recipient. In June 1975 through June 1976, DHR had no cases of child abuse or neglect from the migrant community. No staff members dealt specifically with migrants and there had been no recent staff training to deal with the problems of migrants. In addition, there were no former migrants on the staff, and there was no research being conducted by DHR on migrants. DHR had no provisions to ensure continuity of services for migrants except through contacting an agency at the migrant's home address.

Child Care

Day Care is provided in Somerset County in the Westover migrant camp. The center is funded jointly by the State Department of Human Resources and the Board of Education. The center is administered by the Tri-County Migrant Committee (TCMC). The center services 25 to 30 children, aged two to five, in a ten-week program. However, as there are usually up to 45 requests for day care, all of the children in the camp needing day care cannot be accomodated. The staff of the center is partly bilingual and includes both Hispanics and Blacks; two former migrants work as teacher aides. Health care is provided by a doctor who visits the center once a week, and the weekly health clinic run by the Del-Mar-Va Eccumenical Agency.

After the ten-week summer program ends, some of the children enroll in the Westover school Title I Migrant Kindergarten Program. Despite the apparent success of the day care program, several problems were reported in addition to (the inability) to serve all eligible children. The staff complained of frequent surprise inspections, often at 8:00 a.m., by the local health official. They also reported that the camp owners were often uncooperative in providing space and facilities. In addition, there was a lack of day care for most infants and toddlers. Children under two years of age cannot be accepted without a waiver of licensing regulations from the local health department; furthermore, funds are not available to care for more than two or three children so young.

In addition to the center in Westover, Shore Up!, Inc., runs a 13-week Migrant Head Start program in the town of Salisbury, in Wicomico County. This program, serving 20 three and four-year old children is administered by the East Coast Migrant Head Start (ECMHS) project, which also provides funds for health care at the center in Westover. There is no day care on weekends or holidays, nor any day care at all for infants. Also, transportation is a major problem because there is only one bus.

Day care for migrant children is also provided through the Migrant and Seasonal Farmworkers Association (MSFA), which purchased 13 slots from the Princess Anne Day Care Center in Somerset County. MSFA also provides day homes for 24 children, aged 6 to 18, after school hours if the parents are in job training programs or working.

Education

Educational programs for migrants were visited in Salisbury, Maryland (Wicomico County) and in the Westover Elementary school in Princess Anne, (Somerset County). The school in Salisbury employs 17 staff members and provides services for 46 migrants. Another 32 have an educational program in the camp in the evening. Services provided include health diagnosis and treatment, immunizations, and a breakfast program. The school also uses the MSRTS. The Title I Migrant summer program provides an additional follow-up after summer school closes. At that time, two teachers go to the camps to work with the children. The teachers assist in academic areas and in recreation, such as field trips, until the children begin the regular school program in the fall. This summer program was felt to be highly successful.

Health

The Del-Mar-Va Ecumenical Agency Health Project serves nine counties on the Eastern Shore of Maryland and nearby areas. The staff consists of three doctors and two nurses; of the five, two are bilingual. However, the clinic treats only primary complaints; no physical examinations or preventive care is available. Dental care and immunizations are provided through the Public Health Service facilities and referrals are made to PHS for other services the clinic cannot provide. A serious problem is the fact that the local hospital has limited resources, and no hospitalization funds are available through Del-Mar-Va, making it difficult to pay for emergencies. Further, there is only a limited number of doctors in the area, and those who are available are frequently overworked. The clinic tries hard to meet the community's need for health care, and provides extensive outreach services, including transportation, advertising, and some health instruction; of the 16 outreach workers, three are bilingual. In addition, the clinic has regular staff training sessions on the needs of the migrant community. However, the generally limited facilities and services in the area make meeting the needs of the migrants a difficult task that remains partially unfulfilled.

The other major provider of health care is the East Coast Migrant Project (ECMP), which, with six outreach workers, serves 880 residents in six camps. They provide health counseling and referrals to the PHS for physical examination, immunizations, and treatment of venereal disease, or to local doctors for other routine procedures. They reported that seeking health care can be difficult for migrants due to the lack of telephones in the camps. In one camp, the crewleader, beset by his own difficulties and sometimes uncooperative, had the only telephone in the area in his own house.

Farmworker Organizations

Two farmworker organizations operate in Maryland: The Migrant and Seasonal Farmworkers Association (MSFA), a North Carolina-based organization; and the Tri-County Migrant Committee (TCMC), operating in Somerset, Wicomico and Worcester Counties.

The Migrant and Seasonal Farmworkers Association had been in operation in the state of Maryland for only a few months at the time they were interviewed for this study. They had not yet analyzed the services being provided by other agencies, though they had begun meeting with representatives from several social service and health agencies. MSFA was attempting to address the crucial child care problem in the state by purchasing 13 slots from the Princess Anne Day Care Center in Westover. This purchase was funded by the Department of Labor. No facilities were yet available for caring for infants and toddlers, though MSFA was negotiating with a local branch of the state university to establish a center for these children. Day homes are provided to about 25 children aged 6 to 18, while the parents are working or in training programs. In addition to child care, MSFA also assists migrants in purchasing food stamps, and provides outreach services for health care, child care, food stamps, and nutrition education.

The other farmworker organization, TCMC, was originally sponsored by a church organization, and still maintains contact with church groups through contributions for migrant children. TCMC administers a day care center, in the Westover migrant camp which is paid for by the state. The program also attempts to identify job possibilities for youth, and provides vocational training in the camps.

State Service Provider Agencies

Social Services and Child Care

The Maryland Department of Human Resources (DHR) does not identify migrants by classification in most of its records; thus, no estimates of the numbers of migrants served can be made. However, DHR purchases 30 day care slots which are subcontracted to TCMC for migrant children in Westover. In addition, three migrant women are paid to care for migrant children up to three years of age in a few camps. However, DHR has recently reduced its funding for day care, as the cost is being picked up by Title I Migrant Education. No other services are provided specifically for migrants, and any migrants receiving other services are not identified. For instance, the protective services division has no record of service provision to migrants, and no knowledge of special needs for services by migrants. While outreach services are provided, no special efforts are made for the migrant population, and no special staff is available. According to DHR policy, knowledge of special needs, based on past data, is used to assess the extent to which needs are currently being met, but this assessment is made only for groups for which data are already available. Since data has not been kept on migrants, the need for special services cannot be determined, and therefore no special services for migrants are provided.

Education

Title I Migrant is the chief provider of educational programs for migrant children, operating in 61 schools in eight districts. Throughout Maryland, 1,585 children were served in 1975-76, an increase of 485 over the previous year. Of these, 1,111 are enrolled in the Title I Migrant Summer program. Title I Migrant provides a wide range of services, including health care and treatment. Dental screening and treatment are available to all children in summer school, and vision and hearing clinics are available as needed. Also offered to students are accident insurance, psychological counseling, and a breakfast program. Day care funded by Title I is provided in seven districts and serves 82 children. However, day care is provided only when it is needed to free an older child to attend a Title I program. In addition, three LEA's fund secondary-level vocational training programs enrolling a total of 382 students: The students in these programs receive stipends of $2.00 per hour. For all educational services, outreach and recruitment are utilized. Furthermore, outreach workers have attempted to locate settled-out migrants in the Baltimore metropolitan area.

Health

The Department of Health and Mental Hygiene does not identify migrants in its records, so it is not known how many migrants have been served, although there was a program aimed specifically at migrants in the early 1960's. Health services are available to all individuals requesting them, but there is no bilingual/bicultural staff nor any outreach services for migrants. The decision to conduct programs targeted at special populations is made at the discretion of each county, and the state DHMH does not impose its policies on the county governments which feel a responsibility to the local residents, rather than to migrants.

CHAPTER VII

MICHIGAN: BERRIEN COUNTY

Approximately 34,000 migrants work seasonally in Michigan. An estimated 21,000 of all migrants in Michigan are children. Berrien County, the target county for this study, is in the southwest corner of Michigan and borders on Lake Michigan. This county is the entry and departure point for virtually all of the migrants who work in the state. The work season in Berrien County extends from early May to late November and includes the harvesting of crops such as apples, cantaloupes, corn, grapes, peaches, and strawberries. Because of its strategic geographic location and extensive agricultural production, Berrien County has the largest concentration of migrants in Michigan. This large influx makes migrants more visible than in other areas and strains delivery systems for provision of education, health, and social services. As a result, migrants often become targets for community resentment and are sometimes exploited. Thus, while migrants provide the necessary labor for local agricultural production, community attitudes toward migrants make it more difficult for them to receive social services in Berrien County than in any other county in Michigan. Service provider agencies in neighboring Cass and Van Buren Counties are more accommodating and absorb some of the responsibility for service delivery to migrants living in Berrien County.

Services and Needs in Berrien County

Berrien County was the target county for this study due to the fact that it has the largest migrant population in Michigan. The county boundaries, however, represent an arbitary political division which does not coincide with either the concentration of the migrant population or, in some cases, with the services provided. Berrien County migrants receive services in other counties which are paid for with Berrien County funds. In addition, migrants may move from county to county depending on the availability of crops. These factors combine to make estimates of numbers of children needing services in Berrien County extremely difficult.

Social Services

The county Department of Social Services (DSS) is located in Benton Harbor, a city on the western border of the county. A center for Food Stamps application staffed by the county DSS is also at Benton Harbor. Records kept for services provided at the county level do not identify migrants as a separate population. Thus, no estimate could be made of services received by migrants, with the exception of migrant day care services which are paid for by the DSS. However, accounts of the actual number of children served varied. DSS estimates were high, and indicated that approximately 730 migrant children were served at day care centers and in camps with supervision by aides. Day care center directors estimated that a total of 160 children are provided with day care by DSS. The significant discrepancy between these estimates cannot be fully accounted for even by calculating the number of children served by aides in the camps.

Berrien County DSS personnel began to cooperate in 1976 with the Texas Migrant Council (TMC) to provide protective services for migrant children. DSS estimates that twenty children received such services during the past year. The TMC staff person, however, reported only one case in a six-week period.

The county employs a total of 17 bilingual/bicultural workers, including two former migrants, in various positions during the summer. Seven of these staff members work in food stamp operations, and one of these provides outreach. Three social service workers and three day care aides are bilingual. The remaining four bilingual workers provide clerical help. The large number of bilingual DSS staff members would seem to enhance the probability of effective services delivery to the migrant population. Many respondents in the county, however, reported that Berrien County provided fewer services to migrants than did neighboring counties. The Michigan Migrant Legal Action Program (MMLAP) lawyers reported that it is more difficult to obtain food stamp certification in Berrien County than in any other county in Michigan. They indicated that income verification requirements are stringently enforced and that food stamps are not provided in one-week allotments which makes it difficult for families to save enough money to buy food stamps. Respondents also reported a general lack of concern by the DSS for the problems of migrants. During the previous year, the MMLAP brought 31 law suits against the Berrien County DSS. Most of these suits resulted in changed regulations which helped to guarantee migrants equal access to services.

Outreach to families is provided by a food stamp outreach worker and a migrant services worker who supervises migrant aides. Considering the large number of migrant children of day care age, many respondents felt the outreach provided was inadequate.

Day care center staff members receive training, but it is limited to a one-day session in which they are instructed in the completion of record-keeping forms. The DSS staff participated in developing the statement of need for additional migrant day care prior to the opening of the Andrews University Center in neighboring Cass County.

The Tri-County Migrant Services Committee meets to coordinate services in southwest Michigan. Members include representatives from DSS, the farmworker organization, Title I Migrant Education, the Michigan Employment Security Commission, Andrews University, and the Council of

Churches. DSS staff felt that participation on the committee was helpful in contacting other agencies for future referrals, but that no substantive decisions were reached. Other members reported that the meetings were unproductive and felt there was no reason for continued attendance. The committee publishes a brochure for migrants listing agencies and organizations which provide services in southwest Michigan.

Berrien County DSS personnel suggested several changes to improve service delivery to migrants. They would prefer to hire summer workers at an earlier date and to license day care centers locally. Presently, the state has the responsibility for licensing centers. The county DSS suggested that a procedure be created to provide temporary, less stringent licensing for seasonal centers. The DSS director indicated that his efforts to increase the availability of services to migrants had been rejected. Several years ago, he submitted a proposal for projecting a migrant family's income on a yearly basis in order to facilitate social services. The local DSS also tried to secure the use of a building in Berrien Springs to be shared with the Michigan Employment Security Commission (MESC) which would be more accessible to migrant families. DSS staff members reported that anti-migrant sentiment in the community prevented the acquisition of the facility. Generally, Berrien County DSS staff members feel they are sensitive to the needs of migrants and that the primary responsibility rests with the state DSS.

Child Care

Nearly all day care for migrants is provided through programs designed especially for migrants. This is due to the fact that locally licensed day care centers and home day care services in Berrien County are often reluctant to accept migrant children. Such services also lack the capacity to absorb the great numbers of migrant children who arrive in the summer. Availability of targeted programs varies according to the age of child, the time of season, and, often, the participation of older siblings in the Title I Migrant Education program. An eight-week summer preschool/day care program is operated by Title I Migrant funds and serves about 250 children, ages 30 months to 5 years, whose older siblings are enrolled in the Title I Migrant school-age program. The Council of Churches operates the only other migrant day care center within Berrien County. It operates with Department of Social Services funds and serves about 66 children between 30 months and 5 years old.

The remaining preschoolers are provided day care in either Cass or Van Buren Counties. The Cass County Center in Pokagan is run by Andrews University with DSS funds. About 90% of the 70 children at the Pokagan Center are from Berrien County. The Van Buren County Center at Keeler is operated year-round and is also funded by DSS Title XX monies. It was administered by United Migrants for Opportunity, Inc., (UMOI) until late 1975, when the center director withdrew from UMOI sponsorship in favor of a direct relationship with DSS. It serves 50 children, many of whom come from Berrien County.

According to estimates of the various day care providers, there is adequate day care for children 30 months to 5 years old during most of the summer, the time when all centers are open. Title I Migrant programs for preschool children operate from June through August but close two weeks before the opening of school in the fall. The Council of Churches Center closes September 3rd due to staffing difficulties, even though the center is still full. The Cass County Center closes the third week in September but in 1975 still had 50 children at the time it was due to close. The only center remaining open past September is the year-round center in Van Buren County which could not accommodate all the children who need day care in the late fall even if transportation from all the Berrien County sites were available.

The need for infant care among Berrien County migrants is largely unmet. Seven infants, ranging from several weeks to 30 months old, are cared for in the Council of Churches Center. Additionally, a small number of infants are cared for in the Cass and Van Buren County Centers.

Programs offered in the different centers vary somewhat, but all of the centers serving migrant children provide an educational program, health services, meals, and snacks. The amount and quality of interaction with children varies in the centers observed. In some of the centers staff seemed pleasant, warm, and personal despite hectic conditions.

With the exception of preschool programs funded by Title I Migrant Education, the day care centers utilize DSS funding which complicates their administration. Advance funding from DSS is available only on a projected basis for children under 30 months. These monies help pay for start-up costs but are often insufficient. The Council of Churches Center borrowed money from other church funds for start-up expenses and was not reimbursed until late in July. There are six DSS registration forms for each child, and if a center accepts a child who is later ruled ineligible, DSS will not reimburse for the care provided while the child was in the center. The Council of Churches Center spent $600 for children who were later ruled ineligible for care. Although registration forms are processed through county DSS offices, all financial matters must be directed to the state level. Day care center directors have encountered difficulties in locating the persons responsible for the different administrative functions of DSS.

Problems common to most of the programs were inadequate transportation and lack of facilities. None of the programs had sufficient money to provide enough vehicles for transportation so that children did not spend excessive travel time in buses or vans. Center directors and county DSS personnel stated that community support in offering facilities for day care was extremely limited. Plans to provide additional and more accessible day care and DSS services to migrants in central Berrien County were thwarted by community opposition.

Education

School-aged migrant children in Berrien County are served in the Title I Migrant summer school programs at three schools. A few of the children stay most of the winter and continue to receive either tutoring or small group work, depending on the number of students in each grade. The program provides special academic help and ensures access to school lunches and medical care. Outreach workers also inform families of other available services, such as clothing and food stamps. The program director obtained prompt returns when requesting information from the Migrant Student Records Transfer System. The academic reporting was often vague, but health information was useful.

In the summer, Title I houses its preschool programs in the school facilities. When the schools close for fall cleaning, the day care program is terminated and the school-age program is recessed for two weeks. During this time the nutritional health of the children may suffer as they are not receiving school breakfasts and lunches.

The entire staff of the Title I Migrant education program is very sensitive to the community reaction to migrants. The local director regards himself as a guest in the school district and appears to have no power for negotiating with the local school board as the existence of Title I Migrant programs is a local option.

Health

Health care is available at the migrant clinic located in a hospital at Berrien Springs. The migrant clinic is operated by the Berrien, Cass, Van Buren Corporation (BCV). This nonprofit group developed from the program offered by the county health department. When funds were first made available through the Migrant Health Act, the county health administrator applied for and received monies with which he ran an effective health program coordinated with all migrant service agencies in the county. A few years later, when the Migrant Health Act was amended to require that 51% of the governing board were to be migrants, the county health department could no longer administer the program as the board of the health department is appointed by elected officials. Thus BCV was formed; the staff includes some of the people who had been part of the migrant health care program under the county administration.

Services provided by the clinic include the general range of health care services and the WIC nutrition program. The WIC program holds 100 slots reserved for migrants but these are insufficient for the demand in the early summer. Eye and dental care, which had previously been available, have been terminated due to a lack of funds. Nutrition education is provided through the WIC program. The amount of outreach to camps and provisions for continuity of health care were undetermined. Clinic staff reported the most frequent migrant health problems were diarrhea and skin irritations caused by pesticides.

The BCV administration was inexperienced when it assumed responsibility for migrant health care, and many problems still remain to be solved. Difficulties faced by migrants in need of care include long waits for attention, no emergency care on weekends, and, as is usual, a rotation of doctors.

Respondents in all areas of migrant service in Berrien County cited the difficulty of resolving problems with residents of Berrien County. The acquisition of facilities for migrant programs has been blocked in various ways for many years by local residents. Available facilities are not given rent-free for migrant programs; also, reasons are found for not even renting facilities to migrant service providers. A small number of dedicated people seem to be responsible for the gains made in cooperation. The minister from the Council of Churches in charge of the day care programs has a long history of involvement in services to migrants and overcame many obstacles through perseverance. The county health department administrator had justified his early involvement in migrant health to the community in terms that highlighted community benefits, such as the control of infectious diseases. While service providers are to be commended for their work under such adverse conditions, their power to produce change is severely limited. Strong state support and, perhaps, intervention on behalf of farmworkers is needed if child welfare services are to be available and accessible to migrants in Berrien County.

Farmworker Organization

United Migrants for Opportunity, Inc. (UMOI) is the farmworker organization in Michigan. Its main functions are those included in its services as a grantee of CETA. Statewide, UMOI provides adult training and job placement supplemented with services such as emergency aid and referrals. Services provided through CETA have been reduced due to funding cutbacks from the Department of Labor. Although UMOI does not provide day care services, it does have a health and family services coordinator who offers administrative support to five migrant day care centers receiving DSS funding. This coordinator was new to the position and was somewhat dependent upon local directors of centers for information. However, she has the potential to become a helpful resource person to the day care centers by providing curriculum development and facilitating procedural matters with DSS.

UMOI has an area office in Van Buren County and maintains a satellite office in Berrien Springs in central Berrien County. There were several indications that local UMOI offices were not very effective. Although the Van Buren County day care center was under UMOI sponsorship, the day care personnel perceived no advantages in affiliation with the organization and planned to sever the relationship. This is unfortunate since UMOI and the day care center are in neighboring facilities and some of the potential advantages inherent in good coordination include ease of referrals, cooperation on special projects, and shared expertise in migrant advocacy.

Some respondents indicated that migrants experience long waits for services at the UMOI offices. The funding cuts may have contributed to less efficient service delivery and to a decline in staff morale. An additional hindrance to the effectiveness of UMOI is its previously close association with the Michigan Migrant Legal Action Program. The program has been very active in bringing law suits against Berrien County growers and the Department of Social Services. Although UMOI and MMLAP no longer share facilities, UMOI still bears the stigma of the relationship. Both organizations are regarded by county growers as working in complete opposition to their needs as employers. There is much local antagonism between the two groups, and very little progress has been made toward reaching mutually acceptable solutions.

State Service Provider Agencies

Social Services

The state Department of Social Services provides a wide range of services. Migrants may qualify for all services, but it is easier to gain access to some services than to others. For example, there are no eligibility requirements for receiving protective services. Migrants are not identified as a subpopulation in DSS records, so the number of migrants provided with adoption, foster care, protective services, etc., is unknown. Information provided by UMOI indicates that approximately 455 migrant children are provided day care with DSS Title XX funds. The protective services unit has a cooperative arrangement with the Texas Migrant Council for providing continuity of care for migrants in-stream. TMC had one reported case of migrant child abuse or neglect in Michigan in the six weeks of late summer.

Sixty DSS employees in the state, mostly summer eligibility workers, are migrants or former migrants. State officials reported that services are worse in Berrien County than elsewhere due to the local residents' attitudes toward migrants. The State Migrant Affairs Coordinator stated that services are much better and more extensive in other counties.

The Department of Social Services completed one study that outlined the health needs of Indians and migrants in Michigan in 1975. Another study is to be undertaken evaluating all services to migrants in the state.

It was suggested that, often, federal guidelines for social service programs are problematical, even though the program ideas and the amount of funding do not pose problems. DSS staff reported that Title XX did not improve services, but rather added excessive paperwork to the process of service delivery.

Despite the interest in and concern for migrant well-being shown by DSS through studies and evaluations, interagency coordination to facilitate and improve service delivery does not seem to be a priority for the agency. Although formal mechanisms for coordination do exist, progress appears to be slow.

Child Care

Statewide, the major provider of migrant child care is the Title I Migrant Education program. During its eight-week summer program, Title I Migrant Education provides preschool services for about 80% of the approximately 6,000 migrant children under age five in Michigan. United Migrants for Opportunity, Inc. sponsors most other migrant child care programs, all of which are funded by the Department of Social Services.

Title I Migrant is encountering serious problems in its provision of day care. Many of these problems are related to licensing; that is, meeting standards for fire regulations and the provision of equipment for young children. Additional problems lie with the provision of transportation. Lack of money is the obstacle to resolving both types of problems. Local directors report that it is increasingly difficult to continue offering preschool services while, at the same time, adhering to guidelines which permit the preschool program to operate only when it does not detract from the school-age program. Generally, however, Title I Migrant preschool programs seem to run much more smoothly than do those funded by the Department of Social Services.

Several aspects of the administrative structure of Title I Migrant funded preschool contribute to the smoother functioning of its programs. First, Title I Migrant is assured of facilities at local schools in advance each season, so staff is spared the task of locating and renovating facilities. Second, the program is funded in advance which enables each school to have a secure source of start-up funds within its preschool budget. In addition, Title I Migrant preschool administrators have responsibility for handling all aspects of their programs, with the exception of licensing. Thus, local school officials have full control over transportation, storage of materials, and routine procedural matters. As a result, teachers and directors can devote more time to direct service provision.

Although the Department of Social Services has a State Migrant Affairs Coordinator and a Day Care Coordinator, the established structures and procedures are not well adapted to the needs of migrant day care providers. Day care licensing standards are often prohibitive in terms of time and expense required for remodeling of facilities. Generally, fewer changes are necessary for public schools to meet day care regulations. Frequently, it takes six to eight weeks for a center to be licensed. Start-up funds are available for children from two weeks to 30 months old on a projected basis, but are inadequate for centers that also accommodate children from two to five years of age. There are no start-up funds for centers that serve only children between 30 months and 5 years old. The time required to process center licensing applications may not be excessive for permanent centers, which open only once, but it poses a hardship for those centers which open yearly. Completion of enrollment forms for children who may be enrolled in more than one center over the course of the summer is also time-consuming. Strictly administrative matters, such as opening the center, hiring the staff, and enrolling children, consume a greater percentage of time for the seasonal director than for the year-round center director. If these concerns were expedited within DSS, directors would have more time for activities contributing to the development of quality child care programs.

The UMOI Health and Family Services Coordinator may be able to provide center directors with technical assistance in dealing with the DSS and to facilitate directly some of these administrative necessities through better coordination with DSS. She may also be able to provide or seek provision of earlier and more adequate training for day care staffs. Currently, however, the DSS is not able to respond to the administrative and programmatic needs of seasonal centers.

Despite these problems, it appears that child care programs statewide during the summer months serve about 80% of the migrant children. Title I Migrant Education serves approximately 4,000 children. UMOI administers services to 455, and the Council of Churches serves approximately 100 children. The major problems are the difficulties of service provision in Berrien County--where the greatest concentration of migrants is found--and the extensive need for child care in the fall.

Education

Almost 11,500 school-aged children are enrolled in Michigan's Title I Migrant Education program. Its funding is wholly federal. Twenty percent of its directors and aides are former migrants, as are 75% of its outreach workers, but only 1% of the teachers are former migrants as classroom teachers from various local schools teach in the program. The program is reportedly very effective on a statewide basis except in those districts where community receptivity to migrants is poor. State Title I Migrant staff people visit districts with poor community relations and provide information to raise the awareness and sensitivity of school officials. The provision of Title I Migrant Education programs is possible only through the willingness of local school officials to participate.

The academic program is designed to improve skills in basic subjects for the children enrolled in the program. Many supplemental services are provided also. These include health and dental screening and treatment, a breakfast program, and access to psychological counseling and secondary-level career counseling. The MSRTS computer system maintains student records on both academic and health data for schools to retrieve. The staff felt that the health information was more helpful than the achievement data since educators tend to prefer their own tests, methods, and materials for academic evaluation. The MSRTS was found useful in accounting for and identifying migrant children and in discovering patterns of migration.

The state director of Title I Migrant Education stated that the InterAgency Task Force, which coordinates services to migrants, had deteriorated and, in fact, wondered if interagency cooperation at the state level was viable without a federal mandate.

Although the state migrant affairs coordinator can encourage cooperation among agencies and organizations which serve migrants, service providers still maintain their own priorities. The Title I Migrant director noted that there was no precedent set of cooperation among agencies serving migrants at the federal level.

Health

In the areas most heavily populated by migrants, health care is provided by two federally funded projects, Health Delivery, Inc., and Berrien, Cass, Van Buren, Inc.

The state funds some services for children for which migrants may be eligible. These are services for crippled children; preschool and adolescents; Women, Infants, and Children (WIC); and the mentally retarded. The administrator of the Michigan Department of Public Health stated that migrants are not eligible for Medicaid programs and that there is no EPSDT program. He felt that the impact of the WIC program was limited due to the fact that the program is usually administered locally.

Provision of other services also varied among health care facilities. In some clinics, no eye or dental care was provided. An additional problem with service delivery was a lack of standardization of fee scales among clinics.

Information from all migrant health care projects concerning services offered, staffing, and program management was unavailable because the department of public health has no authority to coordinate information from the federally funded migrant health projects. There is a funded position available within the state health department for an administrator of health services to migrants, comparable to the existing administrator of health care to Indians. The health department is actively seeking a qualified person to fill the position. It was hoped that this person would be able to secure the cooperation of all migrant health care providers in the state.

Despite the lack of personnel with time to devote to health care delivery for migrants, some efforts have been made at the state level to address these needs. Yearly meetings were held which were attended by directors of state and federal health care projects, UMOI, and Indian and migrant representatives. Attendance of migrants was declining so the health department administrator called a special meeting for providers of migrants' services to discuss some of the problems. Providing continuity of health care for migrants was considered to be difficult due to problems with transference of individual health forms. The lack of disease incidence records for migrants which could be compared with those of nonmigrants, and the imprecision of estimates of the number of migrants in Michigan yearly make it difficult to provide adequate care. Were these two information gaps filled it might be possible to obtain more funding for migrant health.

Several goals in the area of preventive care were proposed. It was suggested that health education for both children and adults be provided, and that nutritionists be added to physician/nurse teams to meet this need to some extent. For program development, it was suggested that a literature clearinghouse be established and that there be coordination of treatment for mental and physical conditions. Specific areas needing immediate attention were those of standardization of health care services and fees, and standardization of DSS regulations governing hospitalization of nonresidents. Recognizing that these proposals demand a steady effort and guidance, the service providers plan to have further meetings for implementation.

CHAPTER VIII

NEW JERSEY: CUMBERLAND COUNTY

During the peak of the harvest season, between May and October, there are approximately 20,000 migrant farmworkers in New Jersey. Some 85% of these migrants are concentrated in the southern and central counties of the state, but migrant laborers may be found throughout New Jersey except for the Newark area. Almost half, or 10,000, of the migrant laborers in New Jersey come from Puerto Rico. About 5,000 Puerto Ricans are flown to New Jersey during the peak season under a contract between the Commonwealth of Puerto Rico and the Glassboro Association. Many of these contracted migrant laborers leave their children behind, so the number of migrant children in the state is low relative to the total migrant population. Department of Education statistics indicate that there are 2,000 migrant children in New Jersey. USDA statistics for 1975 indicate that the racial composition of migrants in New Jersey is as follows: 70% Hispanic, 20% Black, and 10% White.

Cumberland County was determined to be the New Jersey county with the greatest concentration of migrants. This county is located in the southern part of the state inland from the Atlantic and bordered on the south by the Delaware Bay. An estimated 1,600 migrants are in Cumberland County during the harvest season. Of the agricultural counties in New Jersey, Cumberland County is among those with the greatest variety of crops and the longest harvest season. Between April 15 and November 15, migrant laborers harvest asparagus, peaches, peppers, strawberries, sweet potatoes, and tomatoes.

Services and Needs in Cumberland County

Social Services

In Cumberland County, social services are provided by two agencies, the Division of Youth and Family Services (DYFS) and the Cumberland County Welfare Board (CCWB). Both agencies are funded with federal, state, and county monies. The DYFS is responsible for delivery of social services through its district office which serves Cumberland and Salem Counties. In Cumberland County, the DYFS offers a variety of services for children and families. Protective services constitute the primary service offered by DYFS at the local level. The Cumberland County Welfare Board administers income maintenance programs, including Aid For Dependent Children and food stamps. The welfare board provides day care and homemaker services to individuals through purchase contracts, and the staff offers counseling and referral services directly to clients of income maintenance programs. Both DYFS and CCWB are affiliated with the statewide Title XX agency which is the Department of Institutions and Agencies.

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The DYFS is the major provider of social services in Cumberland County. This agency administers the following services: day care, protective services, group home services, foster family care, homemaker services, residential treatment, social services for children in their own homes, emergency shelter for children, and Medicaid EPSDT services. The agency does not provide adoption services at the local level.

All services provided by the DYFS are available to all migrant children. Birth certificates are used for citizenship screening, and staff members report that no migrants have been found to be ineligible for services on this basis. Since DYFS records do not identify migrants as a subpopulation, it is difficult to determine the number of migrants served by the agency. DYFS makes no special provisions for serving migrants, and county staff members report that their agency has "minimal contact" with migrants. County personnel reported that two migrant children received protective services and two migrant children received services in their own homes during fiscal year 1976. In cases of need, continuity of services is ensured by informing migrants of child welfare service providers in other states. The county DYFS staff includes one bilingual person, hired for the general staff, who works as a home service aide in cases of neglect and abuse. There are no staff members assigned to work specifically with migrant families or migrant children, nor is any portion of the county DYFS budget designated specifically for migrants or their children.

Program management activities of the DYFS include formal linkages with the county welfare board and health department. Through referrals, the DYFS maintains informal coordination with the farmworker organization. The DYFS does not contract either the farmworker or other social service agencies for providing services to migrant families or children. There is no advisory board for the district office serving Cumberland and Salem counties. As a result, neither local residents nor migrants are involved in policy decisions which affect the delivery of child welfare services in the county. The DYFS is not presently involved in any activities to develop programs or skills among its staff for migrant child welfare services.

Cumberland County DYFS staff members report that a major problem in serving migrants stems from the fact that migrants are separated from the mainstream of the community. As a result, the needs of migrants are not easily recognized within the community and, therefore, migrants are seldom referred to service providers. The proposed solution to this problem is that the needs of migrants be identified and assessed through on-site visits to migrant camps. It was further suggested by DYFS personnel that the health department make referrals for services after inspecting the camps.

The Cumberland County Welfare Board administers income maintenance programs, purchases day care and homemaker services for individuals, and provides counseling and referral services. Transportation to other service providers, such as health clinics, is provided but this service is limited. Eligibility criteria for CCWB services are universal, and citizenship and residency requirements do not pose a problem for migrants. CCWB staff members report that they have not encountered undocumented workers among their applicants. Since CCWB records do not identify migrants as a subpopulation, it is impossible to determine exactly how many migrants are served by the income maintenance programs and related services. Agency personnel report that the welfare board serves several hundred migrants each year. There are no former migrants on the CCWB staff; however, there are approximately 20 bilingual people on the staff working in various capacities. The Food Stamps outreach coordinator, assigned to work specifically with migrants, makes visits to migrant labor camps and contacts migrant camp owners as part of the job. The welfare board does not take measures to ensure continuity of services for migrants who are moving to other areas.

Program management activities include formal coordination with DYFS and the County Office on Aging, and informal linkages with the farmworker organization, county health department, community action agency, and local voluntary groups. The policy-making board of the CCWB consists of representatives of the agency's staff. There is one Spanish-speaking person on this board, but no community representatives, either migrants or permanent residents.

The major problem faced by the welfare board in services delivery is a lack of coordination between service agencies. CCWB personnel reported that currently there are too many different divisions within the statewide Department of Institutions and Agencies (DIA) and the services are not properly coordinated. Agency staff reported that this creates a number of barriers for clients seeking services: eligibility must be reestablished each time the client seeks services from a different division of the DIA; service providers can easily shirk their responsibilities by referring the client to a different division; clients are frequently shunted from agency to agency. These complications have the same negative effect on service delivery to migrants and to nonmigrants. In addition, staff members noted that the proliferation of agencies leads to duplication of services at both the county and state levels. In Cumberland County, the DYFS and CCWB serve different areas: the DYFS district office serves both Cumberland and Salem counties, while the welfare board serves only Cumberland County. This structural arrangement complicates referrals. The solution proposed for these problems is to coordinate and combine services. There are obstacles, however, to achieving adequate coordination. Previous efforts to avoid duplication of services through coordination have failed. Agency regulations are such that it is impossible to circumvent the need for reestablishing eligibility upon referral of a client.

The Community Action Program in Cumberland County is the Southwest Citizens Organization for Poverty Elimination (SCOPE). This organization offers day care and Head Start programs for children, but migrant children are not served by the SCOPE programs.

There are two church-sponsored agencies in Cumberland County. The Migrant Ministry, based in Vineland, does not offer direct services to migrant children. This organization does provide services, such as emergency housing, to migrant families when needed. The Bridgeton Apostolic Center serves children and families. The only direct service to children is the donation of clothing in cases of emergency. Services to families include emergency food and housing and referral of families to service providers.

Child Care

In Cumberland County, the Farmworkers Corporation of New Jersey (FCNJ) is the major provider of day care and Head Start programs for Migrant children. The farmworker organization operates one day care center in Landisville on a year-round basis, and provides a migrant Head Start program in Vineland from June through October. These child care programs run from 7:30 a.m. to 4:30 p.m., and serve infants, toddlers, and preschool children up to age five. The curriculum for day care and Head Start includes educational and remedial instruction and field trips in the community. The support services provided for children in these programs include transportation, meals, immunizations, and referrals to the migrant health service of the county health department. The day care center at Landisville is funded by CETA, and the East Coast Migrant Head Start Project supports the summer migrant Head Start program in Vineland.

The day care center in Landisville serves approximately 40 children whose parents are seasonal or migrant farmworkers enrolled in CETA training programs. The farmworker organization operates this center and is licensed to provide day care for infants, as well as preschool children. The staff includes bilingual persons and former migrants working in various capacities, primarily as teachers and teacher's aides. Migrant parents have a role in the day care program through their participation in the Parent Advisory Council of the center. Outreach services for the day care center are provided by FCNJ staff members who recruit parents for CETA training programs and enroll their children in day care programs, which are provided as a support service for job training. Day care center personnel have participated in training sessions. Day care is coordinated with the Migrant Health Services (MHS) program of the county health department to provide health care to migrant children; it maintains some contact with the local-level DYFS.

The Migrant Head Start program serves 63 migrant children, and is not open to children of seasonal farmworkers. This program begins June 1 and ends October 29. The harvest season in Cumberland County extends from May to October, although migrants begin arriving in the area in early April, and arrived one month ahead of schedule in 1977 due to bad weather in the south. There are bilingual people and former migrants on the staff who work as head teacher's aides. Migrant parents are not involved in program planning or evaluation, as the Head Start project has no policy-making or advisory board. The farmworker organization operates the program and, as an advocate for migrants, would have responsibility for responding to the interests of migrant parents. HEW employees have provided training sessions relating to nutrition and early childhood development for the Head Start personnel.

The migrant Head Start program coordinates with a number of local service providers to supplement the support services it offers. Continuing contact is maintained with Migrant Health Services to provide health care. A nurse from the county health department visits the Head Start program regularly to monitor the health of the children, and the health coordinator of the local schools cooperates with the Head Start program. There is informal coordination between the county welfare board and the Head Start program.

The day care and migrant Head Start programs confront the same problems in serving migrant children. Neither program is able to meet the existing need for day care and Head Start services. Staff members estimate that migrant Head Start serves approximately 10% of the eligible children in Cumberland County. Head Start personnel are keenly aware of the benefits provided to migrant children in terms of personal care and training, and feel that it is critical that this service reach all eligible migrant children. Both programs lack the resources to provide needed support services such as vision and hearing screenings, medicine, and clothing. Staff members feel that additional funds would make it possible to provide more migrant children with needed day care and Head Start services.

Education

Title I Migrant Education programs are offered in Cumberland County schools in the summer and during the academic year. Title I Migrant services include supplemental instruction in all fields, early childhood day care services, and vocational programs. The major centers of Title I Migrant programs are Bridgeton, Vineland, and Fairfield Township, which serves the districts outside Bridgeton. Title I Migrant programs in Bridgeton and Fairfield Township serve migrant children from age five through sixth grade, while Vineland programs serve migrant children from age four through twelfth grade. Support services for migrant education include transportation, health referrals, breakfast, MSRTS, outreach, social work, career counseling, and preschool day care. The length of summer sessions is determined locally and ranges from seven to eight weeks in Cumberland County. The mid-August closing date precedes the end of the harvest season, so migrant children are left unattended until the opening of school in the fall. Summer sessions are operated from 8:30 a.m. until 4 p.m. on weekdays.

Vineland and Fairfield Township schools operate summer sessions for migrant children. Bridgeton LEA does not operate a summer program because there are too few students to sustain it. Migrant children in Bridgeton are transported to Fairfield Township for summer programs. A total of 400 migrant students, aged three through twelfth grade, participated in the eight-week summer session in Vineland in 1976, and it is projected that 475 migrant children will be served in 1977. The seven-week summer session in Fairfield Township serves both nonmigrant and migrant Title I children in kindergarten through sixth grade, and accommodated 100 children in 1976, 60 of whom were migrant children. The summer programs run from 8:30 a.m. to 4 p.m., and the curriculum includes reading, mathematics, health, and arts and crafts. Meals are provided to students in both school districts during the summer.

During the 1975-76 academic year, Bridgeton schools served approximately 75 migrant children, Vineland schools served 435 children. and 20 migrant children were accommodated in Fairfield Township. Since Vineland schools serve high school students, their program includes vocational instruction and high school equivalency programs which are designed to accommodate students who may be working during the daytime hours. Mobile units are a part of the migrant education program in Vineland schools. A full range of educational services, including supplemental instruction for standard academic courses and vocational training, is provided in trailers which move from school to school. Some migrant children ages three and four receive a standard preschool curriculum as participants in school operated day care programs in Vineland and Bridgeton. Preschool programs are extremely limited; less than 20 migrant children participated in Vineland last year.

Schools in Cumberland County offer a number of support services to migrant students which include transportation, health diagnosis and treatment, and outreach. In Vineland, Title I Migrant funds are used to contract private doctors to offer health treatment to migrant children, whereas in Fairfield Township, health treatment is state funded. Immunizations are offered at the schools in Vineland and Bridgeton, if needed, but are not provided by the Fairfield Township LEA. Fairfield Township schools operate a breakfast program year-round while Vineland schools provide a snack year-round, but run a breakfast program only in the summer.

The MSRTS is maintained and used in all three school districts. The farmworker organization has provided training to people who enter information into the system. The Vineland LEA employs one clerk full-time to maintain MSRTS records. School officials report that the MSRTS has improved, and it now functions efficiently providing useful information about migrant students. It was also noted, however, that the system involves much paperwork, needs to work faster, and functions less efficiently at the state level.

In Cumberland County, the Title I Migrant staff includes 16 bilingual persons and 6 former migrants. These people work as teachers, teacher's aides, recruiters, and counselors.

Title I Migrant programs are coordinated with migrant parents and with local social service providers as part of program management. Migrant parents are invited to participate in local level Title I Councils, through which they contribute to curriculum planning. Vineland schools provide transportation for migrant parents to attend Title I Council meetings and other school functions during the summer. Experience indicates that migrant parents tend to visit the school only when their children are involved in a performance or similar activity, and school officials stated that they wish there could be more participation from migrant parents. Each LEA in Cumberland County maintains linkages with the county health department, Migrant Health Services, the county welfare board, and the DYFS district office. None of the LEAs coordinates with the farmworker organization, East Coast Migrant Head Start, or SCOPE, the local community action program. In 1973-74, the New Jersey State Migrant Education Office gave training workshops to Bridgeton Title I staff members to sensitize them to the unique needs of migrant and Hispanic children. This is the only instance found of program development activity in the Title I Migrant programs in Cumberland County.

The needs and problems faced by Title I Migrant programs in Cumberland County vary from school district to school district. In Bridgeton and Fairfield Township, English as a Second Language and bilingual programs are badly needed. Statewide, there are no required qualifications for people employed as teacher's aides, and local Title I officials identified the lack of well-educated, skilled personnel as a detriment to migrant education. Fairfield Township school officials indicate that, in addition to more bilingual personnel, they need more staff to offer individualized instruction and preschool education, and training on how to work with migrants. The need for preschool services for migrant children was underscored because teachers report that migrant children entering kindergarten lack the background necessary to perform well. In both Vineland and Fairfield Township, migrant education staff members indicate that they are able to recruit and serve most of the migrant students in their school districts.

In addition to Title I Migrant programs, there is a Title VII Bilingual Education program for migrants in Cumberland County. This program is only available, however, at the Vineland schools. Bilingual education is provided for children in grades one through twelve. The program staff includes an ESL instructor and remedial and supplemental instructors to aid in the transition to monolingual classes. The Title VII programs in Vineland include the same support services as those provided under Title I Migrant programs.

Health

The major provider of health services in Cumberland County is the Migrant Health Services (MHS), a unit of the Cumberland County Health Department. The MHS clinic is located in Bridgeton, and offers a variety of health services to migrant children. The funding sources for MHS are federal (HEW), state, and private.

MHS provides pediatric care, physical examinations, dental care, immunizations, and home health and outreach. All migrant children are eligible for these services as the MHS does not conduct eligibility screening. In fiscal year 1976, a total of 190 migrant children received health care from MHS as follows: dental care, 20 children served;

immunizations, 15; home health and outreach, 65; pediatrics, 55; physical examinations, 35. The most common illnesses encountered among migrant children in Cumberland County are upper respiratory infections, gastroenteritis, parasites, and caries. Staff members estimate that their services meet the health needs of approximately 75% of the migrant children in Cumberland County. MHS has a number of special provisions which facilitate the delivery of health services to migrants. The clinic operates in the evening, transportation is provided to and from the clinic, and the MHS staff includes outreach workers who are bilingual. The clinic is unable to operate a health education program as no funds were obtained for providing this service. The clinic staff is comprised of two doctors, two nurses, and three health aides. There are no former migrants on the clinic staff.

The major activities of the MHS clinic in the area of program management are coordination with other organizations and interagency and interstate referrals. Since the MHS is a unit of the county health department, health facilities are shared between these two organizations. The MHS coordinates with the state health department, and draws on state funds provided through the Urban and Rural Health Program to finance inpatient care for migrants. Members of the farmworker organization sit on the advisory board of the MHS. Formal ties exist between the MHS and migrant camp owners as the clinic informs camp owners of health services available to migrants. The provision of health screening and immunizations to migrant children is arranged in coordination with the local schools. The MHS refers clients to hospitals for specialized evaluations. In order to ensure continuity of health care, the MHS utilizes the interstate referral system. MHS has no contracts with private doctors or with other health care providers. There are no program development activites such as staff training and research projects.

Staff members at the MHS clinic identified a number of problems which have adverse effects on health care delivery to migrants. Continuity of health care is often lost when migrants are referred to other hospitals, clinics, or doctors. Mobility problems interfere with the referral process. Also, other health providers tend to be insensitive to the migrant lifestyle. Administrative problems center around poor coordination of services. For example, Title I Migrant Education programs in New Jersey received funds for a mobile dental unit, but the unit did not serve Cumberland County until the 1976-77 school year. MHS staff members suggest that a central agency with responsibility for services to children is needed and that only one agency should be given authority for providing such services. An additional suggestion was that federal programs, policies, and services be coordinated in order to improve service delivery to migrants and migrant children. Funding is a major problem for the MHS. The grant to the clinic has been reduced in the past. The future of the clinic is somewhat uncertain because it is possible that the MHS could be merged with the Cumberland County Health Department (CCHD) in the future.

For migrant adults and children, the CCHD functions as a supplementary health service provider. Eligibility for county health department services is dependent upon residence in the county, and no migrants are found ineligible. The county health department administers the WIC program which served 14 migrant children in fiscal year 1976.

The county health department is funded by the state of New Jersey and operates seven clinics in the county. Department staff consists of four doctors and fifteen nurses and, during the school year, one dentist. There are three bilingual people on the staff of the health department: one outreach worker and two nurse's aides. The department has no contracts with other health providers for service delivery, and is not involved in staff training or research projects. Staff members report that their problems in serving migrants stem from the transience of migrants and the lack of a national coordinating agency to provide health services in each state.

Farmworker Organization

The Farmworker Corporation of New Jersey (FCNJ) is the farmworker organization in New Jersey. The organization presently serves those counties with high concentrations of farmworkers--Atlantic, Cumberland, Gloucester, and Salem counties--all of which are located in southern New Jersey. The organization is gradually expanding its services to the central part of the state and ultimately will have programs and offices throughout New Jersey. The primary objective of FCNJ is to enable farmworkers to benefit from the same rights and opportunities as other citizens. To this end, the organization provides on-the-job training and, with the cooperation of local industries, offers alternative employment to farmworkers. Additional services are provided to farmworker participants in job training and to other farmworkers, and include the following: outreach to farmworkers to link them with services in the community; educational instruction in English and basic communication skills; child care and supportive services; and emergency assistance for food and housing. The 1975 budget of FCNJ was slightly less than $900,000. The majority of the budget ($580,000) is derived from CETA, and the remainder comes from other federal agencies, state agencies, and private funding sources.

FCNJ screens migrants for residency status and income. The screening process is conducted through visits to migrant camps to determine length of residence and through examination of pay stubs. Of those who apply for FCNJ services, approximately 20% are rejected on the basis of residency and 30% do not meet the income criteria.

Migrants play an important role in the decision-making process of FCNJ. An 18-member advisory board includes 13 migrants or former migrants as members and advises the FCNJ director on policy matters. FCNJ has one area council for each of its three field offices; each area council is comprised of 14 persons, 12 of whom are migrants or former migrants. Each FCNJ day care center has a Parent Advisory Council with 14 members, including 12 migrants or former migrants.

FCNJ provides a number of services which respond to migrant child welfare needs. The organization operates bilingual day care and Head Start programs and provides after-school care in the summer in southern New Jersey. The day care and Head Start programs are described in detail in the day care section under "State Service Provider Agencies," below. Supportive services for child care programs include meals, transportation, and health care referrals to migrant health clinics and county health departments. FCNJ day care and Head Start programs maintain informal links with county departments of social services. Migrant parents participate in making policy for day care and Head Start programs as they are members of the policy boards of each center.

FCNJ spokespersons report that services for migrant children in New Jersey are inadequate. There are far too few resources. Lack of resources for child welfare programs is a persistent problem. FCNJ has been actively seeking funds for day care for migrants in recent years with very little success. Twice, the DYFS has cancelled contracts with the FCNJ for day care due to the inability to raise matching funds at the local level. This is but one example of a broad problem of lack of resources to support programs for migrant children. It is estimated that programs run by the federal, state, and local governments reach only about 25% of the migrant children in New Jersey.

There are a number of hindrances to social service delivery to migrant children. FCNJ workers stated that local governments and the state government are unsympathetic to the needs of migrants. Informed estimates indicate that 80% to 90% of underage migrant children work in the fields, and thus child welfare services are less accessible to them than to children in schools or day care centers. Since the legal age for working in the fields is 12, this means that a high proportion of very young children are effectively cut off from services. Poor coordination of programs hinders service delivery to migrant children and adults alike. FCNJ employees reported that there is a lack of coordination of programs at the federal, state, and local levels. The comprehensive annual social services plan of the DIA clearly identifies lack of coordination of state-level programs as a major administrative problem in delivery of social services to the public at large. One result of poor coordination is that the farmworker organization does not receive information about public programs available to migrants. It was suggested that this problem might be remedied by devising a method to inform the FCNJ about the services and utilization of public programs. Another suggestion was that a migrant representative be placed in the governor's office to coordinate public and private programs providing services to migrants, and that an interdepartmental council be established to link together programs operated by state-level agencies. FCNJ staff members feel that the major responsibility for the delivery of services to migrants should rest with a central agency in order to achieve greater coordination, reduce bureaucracy, and provide effective service delivery.

State Service Provider Agencies

At the state level, the provision of social services and health care is extremely complex. The state social services agency is a large bureaucracy which operates a variety of programs through various of its units. Other state agencies administer programs that overlap with those of the social services agency, but coordination of these programs is lacking. Health services is a complicated area because many different providers operate at the local level and there is a lack of centralized coordination and uniformity of services and provider agencies. In contrast, it is easy to gain an understanding of statewide day care services since programs are few. Educational programs for migrants are similar in different parts of the state due to the existence of national guidelines for Title I Migrant Education.

Social Services

The principal social services provider on the state level is the Department of Institutions and Agencies (DIA). The service delivery structure of the DIA is very complex because the agency is an umbrella agency covering virtually all of the state social service programs as well as overseeing welfare programs. New Jersey is one of three states in which social services are administered at the state level and at the local (county or district) level. The DIA offers a wide range of "tangible" services (e.g., protective services, education, training, etc.) and "facilitating" services (casework, information, and referral). These services include Title XX and WIN social services and Title IV-A child welfare services. The state plan for fiscal year 1977 emphasizes the need to shift the traditional focus of the agency and expand specific and tangible services while maintaining facilitating services. A further priority of the DIA is to serve those most in need of services on the assumption that immediate needs of physical well-being are more critical than personal and social development. The funding sources for the DIA are federal, state, and local public and private organizations or agencies. The state of New Jersey utilized 94% of the federal Title XX funds available to it. Local contributions exceed state contributions to Title XX matching funds.

Eligibility for services is determined by the state and the service provider, and is based on income. Citizenship is not a requirement for eligibility for DIA services. The Division of Youth and Family Services (DYFS) of the DIA and the county welfare boards are the two organizations which offer social services used by migrant families in New Jersey. The DYFS is the child services arm of the DIA and provides adoption, foster family care, protective services, day care, emergency shelter care, homemaker and group home services, social services for children under stress, in-home day treatment, institutional care, family planning, maternity home, and Medicaid EPSDT programs. Because DYFS records do not identify migrants as a subpopulation it is difficult to determine the extent to which these programs are utilized by migrant farmworkers and their children. The DYFS makes no special provisions to ensure that social services reach migrant children. It does offer one program designed specifically to meet the needs of migrant children. Through a Title XX contract, the DYFS provides day care to 50 migrant children at a center operated by the Farmworkers Corporation of New Jersey in Woodstown, Salem County. Caseworkers in south and central New Jersey, the area of greatest concentration of migrants, indicated that in fiscal year 1976, no migrant children were served by adoption; fewer than 20 migrant children received protective services, foster family care, or Medicaid EPSDT; and less than 10 migrant children were provided with social services for children under stress, social services at home, emergency shelter care, family planning, and maternity home care. In contrast, 531 children statewide were served by adoption, 27,666 children received protective services, 9,450 children were provided with foster family care, and 22,420 children were served at day care centers throughout New Jersey in fiscal year 1976. In south and central New Jersey, the DYFS staff includes 22 bilingual persons, all of whom were hired to meet general staffing needs.

Coordination with other units of the DIA and with other state service providers is the major activity in the area of program management. Coordination is of critical importance due to the proliferation of social services units and programs within the DIA and in other state agencies. Within the DIA, coordination involves collaboration between the DYFS and the Divisions of Public Welfare, Mental Retardation, Mental Health and Hospitals, and other units of the DIA. State agencies with which the DIA coordinates programs include the Departments of Education, Health, Community Affairs, Labor and Industry, Transportation, and also the Public Advocate. Intra-agency coordination within the DIA is very complex, and will be discussed below. Interagency coordination is less than ideal due to the fact that DIA programs overlap with those of all six other state departments which provide social services. At the state level, the DYFS works with two policy boards, an advisory body, and a supervisory body. At present, supervision of contracts for services to migrant children is a minor aspect of DYFS program management activities since DYFS has only one Title XX contract, with the farmworker organization to provide day care in Woodstown.

DYFS personnel identified day care as the greatest unmet need of the approximately 2,000 migrant children in New Jersey. Migrant children are exposed to many risks in their environment due to inadequate inspection and supervision of working conditions on farms in New Jersey. Day care would reduce the extent to which children are in the fields and are exposed to such risks.

The Division of Public Welfare of the DIA supervises income maintenance programs throughout New Jersey which include Aid to Families with Dependent Children, Assistance to Families of the Working Poor, and food stamps. Service delivery occurs only at the county level and is administered by the 21 county welfare boards. Each client, individual or family, receiving income maintenance services from a county welfare board is offered social services by the welfare board, but the DYFS is responsible for delivery of these services. Like the other social service agencies in New Jersey, the county welfare boards do not identify migrants as a subpopulation, and so it is impossible to determine how many migrants are served by income maintenance programs in New Jersey. It is known, however, that the Cumberland County Welfare Board serves several hundred migrants a year and so it is reasonable to assume that a high number of migrants utilize income maintenance programs administered by the county welfare board throughout the state. Program management activities of the Division of Public Welfare include supervision of the county welfare boards and coordination with other social service providers.

Difficulties with the delivery of social services to migrants and other clients in New Jersey stem from inadequate coordination of services. The New Jersey Comprehensive Social Services Plan for fiscal year 1977 describes the state human services programs as a "maze," and asserts that the need to coordinate such services is evident. The report points out that the "fragmented system" for planning, funding, and delivery of services has created duplication of services as well as gaps in services (New Jersey, Comprehensive Plan, p.76). An example of the complications in the social services delivery system is the division of labor between the Division of Public Welfare and the DYFS. County welfare boards have jurisdiction to serve only one county, whereas the DYFS may serve one or more counties. Although these two agencies fall within the DIA, their relationship to the DIA is different. DYFS is a unit of the DIA while the county welfare boards, under the Division of Public Welfare, are relatively independent agencies which are merely supervised by the DIA.

For clients in need of services, the proliferation of agencies and duplication of services may easily hinder access to services. Local level service providers report that clients tend to be referred back and forth between service agencies. The Comprehensive State Plan recognizes these problems and reports that "current service structure is not optimal" (New Jersey, Comprehensive Plan, p.103). A major activity in the DIA during fiscal year 1977 will be to develop a more rational social services delivery system. To this end, the agency plans to carry out the following activities: conduct a comprehensive analysis of all services and a study to assess service needs, reexamine service priorities, integrate services at the state and local levels, and continue to utilize public participation in the planning process. Until the state coordinates its social services in a rational form, however, the needs of many clients will go unmet. Since there is only one DYFS project addressed specifically to the needs of migrant children, it is certain that the problems they face will persist unless priorities shift and programs expand.

Child Care

In New Jersey, the Farmworker Corporation of New Jersey (FCNJ) is the major provider of day care to migrant children. The State Title I Migrant Education Office has assigned the responsibility for preschool care to the farmworker organization. Statewide, FCNJ administers day care and Head Start programs for 100 children, ages two weeks to five years. Additional providers of day care include State Title I Migrant summer programs and individual LEAs. Day care programs have varying hours which are determined locally. Generally, programs operate from 7:30 a.m. or 8 a.m. until 4:30 p.m. The curriculum of day care and Head Start programs covers preschool educational and remedial instruction and field trips. Support services include transportation, meals, immunizations, and health care referrals. Funding sources for these programs include East Coast Migrant Head Start, CETA, Title XX, and Title I Migrant monies.

FCNJ operates three licensed centers in southern New Jersey which provide day care and Head Start services for the children of migrant and seasonal farmworkers. These centers are located in Landisville (Cumberland County), Folsom (Atlantic County), and Swedesboro (Gloucester County). With Title XX funds, the state DYFS has contracted the farmworker organization to provide day care to 50 migrant children in Woodstown (Salem County). A summer Head Start program is offered by the farmworker organization in Vineland. In addition, FCNJ operates two summer programs which provide after-school care. The curriculum offered by these programs is bilingual and includes introduction to phonics, science, mathematics, language, and cognitive development at the preschool level. The county migrant health services and health departments, the USDA, and the WIC program provide meals or food supplements, immunizations, and health diagnosis to all participating children. Seventy-five percent of the children receive care through referrals. Health education is not provided by FCNJ. The staff of these programs includes 15 former migrants and one current migrant who work as teacher's aides, cooks, and bus drivers. There are 24 bilingual persons employed as teacher's aides. Outreach services are an important aspect of the complete service program of the farmworker organization. FCNJ recruits migrant adults for its manpower programs while also recruiting children for the CETA-sponsored day care program in Folsom. Migrant children are recruited for other child care programs in the course of standard FCNJ outreach activities.

Migrants are actively involved in the management of day care and Head Start programs through their participation on the FCNJ policy board and area councils and on day care and Head Start Parent Councils. Each day care center has a 14-member Parent Advisory Council, with 12 migrant members, which is responsible for deciding policy for the day care and Head Start centers. FCNJ child care programs maintain formal linkages with migrant health clinics, and referred 125 children to the clinics in 1975-76. There is informal coordination between the day care and Head Start programs and county DSS offices.

Many of the staff members of FCNJ child care programs have participated in training sessions recently. Twenty-seven employees, including 15 migrants or former migrants, attended a seminar on academic and health care. Three child care workers attended a session on special mental and physical health problems, and the director of child care programs has participated in a migrant education orientation.

Funding is the major need of child care programs in New Jersey. Present day care services are limited due to a lack of funds. FCNJ has been and is searching for funds to expand child care programs and increase enrollment and also to build a day care center in Cedarville. To date, the farmworker organization has had no luck in finding financial support for child care services. Funding has been a nagging problem for child care programs. In the past, Title XX funds financed two additional FCNJ day care centers but these contracts were cancelled because matching funds could not be raised.

Title I Migrant Education programs also provide day care to preschool children. Officials of several LEAs indicated that local schools operate day care programs for migrant children ages three and four, but the State Title I Migrant Office did not report on this service.

Education

Title I Migrant Education programs operate throughout the state of New Jersey in the summer and during the academic year. The Migrant Education Office of the New Jersey Department of Education is responsible for Title I Migrant programs and for coordinating Title I services to ensure equal services to migrant children in each county.

Title I Migrant summer programs are offered throughout the state and serve Title I and Title I Migrant students together. Migrant children between the ages of four and fourteen are the priority age group for summer programs since the statewide farmworker organization has responsibility for providing preschool care. The Title I Migrant programs do not serve preschool children who are less than four years old. The length of summer sessions is determined locally, and usually lasts about eight weeks, ending in mid-August. The operating hours of summer sessions are also set by the LEA, and are normally from 8 a.m. to 4:30 p.m. Migrant children study with other students in standard academic programs during the academic year, but are also provided with supplemental instruction.

The State Department of Education employs recruiters in each county to identify and enroll migrant children in LEAs. Some LEAs do not offer Title I Migrant education programs because, officials reported, staffing at the state level is inadequate to do a good job of ensuring that all LEAs apply for program funding. It is impossible to determine how many migrant students are served by Title I Migrant education programs because the information recorded on the MSRTS in New Jersey was reported to be "questionable." In checking the statewide MSRTS records, it was discovered that the files include data on nonmigrant children, and therefore are invalid.

Migrant parents are involved in Title I Migrant programs. As members of the State Parent Advisory Committee, they advise about migrant education programs but do not take part in developing the annual state plan.

Migrant programs in the State Department of Education are coordinated with a variety of agencies to provide additional services. Formal linkages are maintained with the state and county health departments, migrant health clinics, and the farmworker organization. The Department of Education has a contract with the state health department to provide dental care for migrant children. There is informal coordination between the Title I Migrant Education Office and state and district offices of the Division of Youth and Family Services, county welfare boards, and community action programs. There is no coordination with either the State Migrant Affairs Office or local volunteer agencies.

There are a number of problems with the operation of Title I Migrant Education programs in New Jersey. Staff members in the State Office of Migrant Education report that there is a need for greater fiscal control over migrant education programs. The recruiting effort is hindered in several ways. First, it is difficult to find and identify isolated migrant children and to recruit them for migrant education programs. Second, the responsibilities of recruiters are too narrowly proscribed and they should be permitted to counsel students and to process the papers for new migrant students. Lastly, there are too few recruiters to do an effective job of expanding migrant programs and sources to schools and, consequently, not all eligible LEAs apply for Title I Migrant funds, so migrant children are not offered equal or adequate educational services. Two major problems affecting summer programs for migrants were identified by state Title I staff. First, summer programs for migrant children close in mid-August. Migrants work in New Jersey until as late as November, so the closing of summer programs means that children are left unattended between mid-August and the opening of school in the fall. Second, the hours of the summer programs do not match the working hours of parents. Poor interagency coordination was identified as a problem which hinders delivery of services to migrant children throughout the state. It was suggested that the DIA would be the best agency to work with to provide a program of integrated and coordinated services to migrant children.

In addition to Title I Migrant programs, there are Title VII Bilingual Education programs in the state. Title VII Bilingual programs are reported to provide very limited services. Most of these programs are offered in major cities with large concentrations of Spanish-speaking persons. On a statewide basis, Title VII programs serve primarily Puerto Ricans, Cubans, and settled-out migrants in urban areas, and are thus not available to migrant children.

Health

It is difficult to obtain a broad overview of health services to migrants in New Jersey because services vary from county to county, are provided by a number of different agencies, and are coordinated loosely at the state level. In New Jersey, migrant farmworkers are provided with health services by a variety of health care agencies. Some, but not all, counties in New Jersey have county health departments. Migrant Health Programs (MHP) are operated in conjunction with county health departments in several counties. Visiting Nurses Associations provide health referrals, home visits, follow-up, and additional services in some counties. Health services throughout the state are coordinated by the State Health Coordinating Council which includes representatives of the State Department of Health and local level health agencies. The Division of Alternative Health Systems of the State Department of Health is responsible for promoting alternatives to in-patient care and also administers federal and state grants to visiting nurses associations which serve migrant farmworkers. Migrant Health Programs are funded by the federal government throught the Department of Health, Education, and Welfare.

Services offered through county health departments and migrant health programs include immunizations, physical examinations, outreach, pediatric care, and other standard aspects of health care. Migrant Health Programs include special provisions, such as bilingual staff, evening hours, and transportation in order to enhance service delivery to migrants. In those counties where a Migrant Health Program is administered, it is the major provider of health services to migrants while the county health department functions as a supplementary service provider to migrants. In central New Jersey, various state-contracted agencies serve migrants exclusively. These agencies are: the Public Health Nursing Association in Burlington County, the Family Service Agency in Mercer County, and the Family Health and Nursing Services in Monmouth County. These health service agencies handle certain aspects of health care, but do not provide a full array of health services, so the respective county health department would also act as a supplemental health care provider. In Middlesex County, the Visiting Nurses Association serves migrants with comprehensive health care and referrals to doctors. Staff members of the Migrant Health Programs and the health service agencies report that the most common health problems found among migrants are upper respiratory infections and parasites. Additional health problems include skin rashes, anemia, gastroenteritis, eye and foot disorders, and hypertension.

Health services provided by the MHP are different in Gloucester, Salem, and Cumberland counties. All migrants are eligible to receive health care under this program. As a minimum, these programs provide dental care, immunizations, outreach, physical examinations, and emergency treatment. Services in Salem County include specialized disease testing, maternal and child health care, and screening. Neither health education nor the WIC program is provided by the MHP in any of these counties. However, WIC services are available through the Cumberland County Health Department in Cumberland County. In fiscal year 1976, the numbers of migrant children served by MHP programs were 84 in Gloucester County, 250 in Salem County, and 190 in Cumberland County. The Salem County program has assigned a nurse to work at the FCNJ day care center on a part-time basis and to provide nursing services to 25 children at the center. The MHP in Gloucester County serves few migrant children because the majority of the farmworker population there consists of single males, ages 15 to 44. Some state monies are made available to migrants referred for hospitalization by MHP clinics. Neither the MHP nor the county health departments with which they are affiliated are able to provide Medicaid services to migrants. This is because, when working, migrants do not fit the state legislated minimum income requirements ($155 per month) or other eligibility criteria, such as age or number of dependents.

There are several bilingual outreach workers on the staff of the Cumberland County MHP and two bilingual outreach workers on the Salem County MHP staff. The Gloucester program has no bilingual persons or former migrants among its staff members. All three programs facilitate continuity of health care by using the National Migrant Referral System based in Austin, Texas.

None of these MHP centers contracts with other health agencies or with doctors to provide health care to migrants. MHP personnel have not participated in staff training activities, nor have the programs been involved in research related to the health care of migrants. There is formal coordination between MHP staff and county health department staff and some coordination with other health providers. However, MHP staff members noted that there is a need for improved coordination of health services at the local and state levels.

The type of health care provided and number of migrants served by the various health service agencies mentioned above vary greatly. In Burlington County, the Public Health Nursing Association provides nursing visits only, and served 15 migrants in fiscal year 1976 with a grant of $300. The Family Service Agency in Mercer County held consultations with 335 migrants and provided referral and follow-up care to 77 migrants with a budget of $9,873 from HEW. In Monmouth County the Family Health and Nursing Services served 350 migrants with a total of 925 patient visits. The budget for this agency in fiscal year 1976 totalled $7,000 and the project was funded by HEW. The Visiting Nurses Association in Middlesex County operates with a budget of $15,000 and provides comprehensive health care to migrants including physical examinations, immunizations, general health tests, screening, dental and eye care, outreach, referrals, and transportation. These services are provided at evening clinics and reached 250 migrants including 40 migrant children under 18 years of age. The association provides referrals to other health care providers and to public and private social service agencies in the county. All of these county level health agencies are affiliated with a program which subsidizes 50% of the hospitalization costs of migrants. Usually, the four local health services agencies discussed here provide care in case of disease or a health crisis. Thus, migrants served by these programs would also need preventive health care and would have to seek it from another health care provider.

It is not known how many bilingual staff persons are employed by these four health service agencies, but there is one bilingual physician who works with the Family Service Agency. Orientation programs are provided for new staff members.

There are a number of significant problems with health care delivery to migrants in New Jersey. Respondents at several of the health care providers surveyed indicated that the lack of Medicaid services poses a serious problem in terms of health care for migrants. As in other states, much of the health care provided to migrants consists of emergency or crisis-oriented medical attention. Thus, there is a persistent need for preventive care for migrant children and adults. Various representatives of health care providers identified poor coordination of health services as a problem. It was suggested that health services be coordinated through a central state office and that coordination be improved at the local level as well. Coordination would be complicated by the lack of uniformity in health care providers and services offered, as shown by the fact that not all counties have a county health department. This points to a lack of public health services in general.

Previous attempts to expand health services in New Jersey have failed. Twice, the East Coast Migrant Health Project (ECMHP) has tried to initiate health programs in New Jersey, and both times the Project has been unsuccessful in establishing a program. It should be noted that the ECMHP provides only supplemental health services; it does not operate programs that would duplicate or supplant existing health services. The inability of the ECMHP to establish a program in New Jersey has been attributed to strong resistance among local public health and private doctors to any increase in health service providers. At the state level, there is no clear authority empowered to assure proper health service delivery throughout the state, and so local doctors are able to prevent the expansion of health services. It is possible that an additional factor was resistance to a federally sponsored program.

In sum, it may be said that health services to migrants and to the public at large in New Jersey are highly uneven, poorly coordinated, and often deficient. Further, the opportunities for improving upon health services in New Jersey appear to be limited.

Additional Services

The State Migrant Affairs Office in New Jersey is part of the State Department of Labor and Industry. The major responsibility of this office is to enforce child labor laws. New Jersey laws permit children aged 12 and over to work in the fields. Currently, the state legislature is considering a bill that would allow children aged 12 and over to work in food processing plants. On an informal basis, the Migrant Affairs

Office coordinates with migrant program officials in the State Departments of Education, Institutions and Agencies, and Health. Until 1975 the Migrant Affairs Office was affiliated with a committee which coordinated the activities of public and private agencies working with migrants; however, this committee has been disbanded.

A spokesperson for the State Migrant Affairs Office stated that, in general, the needs of migrant children for welfare services are not met and that no program has a favorable impact on meeting those needs. Specifically, there is a need either to build day care centers at migrant camps or to provide on-site day care aides. In addition, health care was identified as an area in which services to migrant children are deficient. The spokesperson said that migrant children do not receive the services to which they are entitled since county residents do not want to encourage migrants to settle permanently in New Jersey.

Staff members of the Migrant Affairs Office reported that each of the current New Jersey programs for Migrants has a different focus. New programs are needed and improved coordination of services to migrants is essential. There is an identified need for centralizing programs by placing a single agency in charge of coordinating services to migrants.

CHAPTER IX

NEW YORK: WAYNE COUNTY

Wayne County, in north central New York, population 67,000, has between 2,000 and 4,000 migrants each year. A census conducted in the summer of 1976 by Program Funding, Inc. (PFI), a statewide farmworker organization, found that there were 4,000 migrants in the county. Many other persons who live there are settled-out migrants and still perform farmwork seasonally. Significantly more migrants are employed in Wayne County than in other agricultural counties in the state, and the county has by far the greatest number of migrant camps. Most of the orchard farmwork is in the northern half of the county near Lake Erie. The predominant migrant-worked crop is apples. Cherries demand less migrant labor due to mechanization. The farmwork season in Wayne County lasts from July through October, with a hiatus in August due to the mechanization of the crops.

The farmworker population in the county is almost totally Black, with the exception of a few Spanish-speaking migrants. The migrant population consists primarily of families traveling together. There are some single men who come with crews, but most travel independently to the county, often returning as "regulars" to places where they have worked in prior years.

The main providers of services to migrant children in Wayne County are as follows: Program Funding, Inc., which provides emergency aid and runs manpower programs; the Wayne County Action Program, which also provides emergency aid, runs manpower programs, and operates one migrant day care center; the Wayne Comprehensive Health Clinic; the Public Health Nursing Service; the Agricultural Extension Migrant Nutrition Program; the State Health Department Regional Migrant Camp Nurses Program; the County Department of Social Services; and the New York State Migrant Day Care Program.

Services and Needs in Wayne County

According to the 1976-77 County Title XX Plan, 12% (8,000 persons) of the population of Wayne County have incomes below the poverty level. This sector is the target population for social services and other types of public programs, such as subsidized health care. The income levels and living conditions of migrants place them below the poverty level. Migrants comprise four to five percent of the total county population; thus one-third of those below the poverty level in Wayne County are migrants.

Social Services

The Wayne County Department of Social Services (DSS) and the Wayne Community Action Program (WCAP) are the two major providers of social services in the county. The DSS administers social services and financial assistance programs. Title XX programs are operated by the Family Services Division of DSS, and the Benefit Payments Division handles financial assistance programs, such as AFDC, Medicaid, unemployment insurance, and food stamps. The WCAP operates manpower training programs, nutrition programs, programs for the elderly, general purpose information and referral, and day care programs.

The DSS services known to be used by migrants are, in order of usage, services for unmarried parents, day care, preventive services, EPSDT, family planning, foster family care, and protective services. As shown in the table below, however, few migrants use these services.

TABLE 1

Use of Social Services by Migrants in Wayne County

Service	Migrants as Percent of Total Clients Served
Services for Unmarried Parents	8.7%
Day Care	3.5
Preventive Services	3.0
EPSDT	1.1
Family Planning	1.0
Foster Family Care	1.0
Protective Services	.7
Adoption	0
Homemaker Services	0
Home Management	0
Chore Services	0

The total number of cases was 3,674. Migrants comprised 2.2% (80 persons served) of these cases.

A number of factors contribute to the low utilization of DSS programs by migrants. It was indicated that funding constraints of the state Title XX program represent the main barrier to improved services. Recently, funds were cut and the county lost one caseworker. As a result, the department cannot expand services to reach more migrants. DSS does not provide services which facilitate migrants' access to programs. The agency has no outreach workers and only provides transportation to service providers in medical emergencies. There are no former migrants or bilingual/bicultural staff members in the social services office. Standard bureaucratic processes may present obstacles to migrants' access to services. The time and procedures required to obtain certain services limit their availability to a transient population such as migrants. Foster family care and protective services, for example, require instigation of a case through complaint, investigation, and disposition before services can begin. With no outreach and few telephones in migrant camps, complaints may not be made even where basis exists for reporting, and by the time all formal steps are completed the family may have left the area because the farmwork season has ended.

It is important to consider the issue of migrants' need for certain social services. Far fewer migrants now use the services of the DSS Family Services Division than did before the migrant day care centers were established in the county. Although the county provides homemaker, chore, and home management services, these may be inapplicable to some or all migrants in the county due to the use of group cooking facilities and other arrangements in migrant camps. In general, the family structure of migrants tends to make adoption an unnecessary service, and by the same token, foster family care is rarely needed.

The other major social services provider in the county, the Wayne CAP, operates several different programs, two of which--day care and the Migrant Manpower program--are explicitly targeted at migrant and seasonal farmworkers who benefit also from several of the other CAP programs. The CAP provides neighborhood service and referral centers; CETA Title I and Title II 303 programs, including jobs referrals; education, summer work, and supportive services; a nutrition advocacy program and nutrition and volunteer programs for the elderly; and day care and Head Start centers. Migrant children are not included in the Head Start centers due to the presence of migrant day care centers and the pressure from the local community to take its own children. The only day care center operated by the CAP used to be a state-run migrant day care center which still serves migrant children.

Child Care

There are three migrant day care centers in Wayne County, and all are supported under the N.Y. State Migrant Day Care Program. Two of these centers are operated by the New York State Department of Agriculture and Markets. The remaining center is operated by the Wayne Community Action Program, and is funded by the Department of Agriculture and Markets on a "purchase-of-services" basis for those migrant children it serves.

The three centers serve 35, 50, and 60 migrant children, totalling 145. Two of the centers operate year-round; the other center serving 50 children is open only in the summer. The number of children the centers are licensed to serve and the number enrolled at any time correspond closely since the centers are almost always filled to capacity. The State Migrant Day Care Program requires that approximately ten percent of enrollments are to be nonmigrant children. Enrollments during the winter off-season months were reported to be more than 50% nonmigrant.

Eligibility for services can be a problem for current migrants. The term "migrant" is defined loosely; the state requires that the family must be migrating or settled-out in Wayne County and the parents must be working or looking for work. Since many agricultural workers in Wayne County originally migrated there to work but now reside permanently, centers have difficulty holding space for the arrival of currently migrating children.

Supportive services at the centers consist primarily of health care. The state-run centers each have one nurse on duty full-time; the WCAP center has a nurse part-time. Children at both state-run centers are provided with physical examinations and, if necessary, are transported to the migrant health clinic for medical care. The nurse at the WCAP center estimated that 20% of the children are taken to the clinic each year. For one of the state centers, this estimate was 100%.

All three centers serve children from infancy up to five years of age. Most of the children are between three and five years old. The centers operate from 7:00 a.m. to 5:00 p.m., five days per week. The program at the WCAP-operated center includes a family corner, science, gymnasium, nutrition, art, blocks, stories, and outdoor activities. At the other centers, the curriculum includes language development, cognitive development, reading readiness, and large and small motor skills. The head of one of these centers is the regional director for the state program and personally developed this curriculum. All of the state program centers operated by the Department of Agriculture and Markets in Wayne and two adjacent counties use this curriculum.

All centers are state licensed, but obtaining and keeping the license can be difficult. The major obstacle to obtaining a license, according to the regional director of state-run programs, is finding a facility and paying for necessary renovations. Day care facilities are scarce, and churches are one of the few available resources. Keeping the license has been a problem for the WCAP-run center. As this center has a different salary structure from the others and experiences a relatively high turnover rate, the staff/child ratio is below the permissible level when there are vacancies.

Each center has a parent advisory board. Migrant involvement varies due to transportation difficulties, working hours, and effectiveness of outreach.

There have been several staff training sessions at all of the centers in the recent past. At the "purchase-of-services" center, these have included training in early childhood development, nutrition education sessions given by the county agricultural extension nutrition program, a one-week preseason workshop, and Red Cross first aid training. At the state-run centers, recent training has included a four-day preschool development training workshop, a one-day course in child development provided by the University of Rochester, weekly curriculum training sessions, and a four-day course in child development offered by the Western New York Child Development Council. One director noted that it is difficult to train aides, especially former migrants, well enough so that the experience assists them in obtaining future employment. This situation should be ameliorated by the implementation of revisions in the statewide program concerning staff organization and duties.

Staffing at both types of centers includes certified teachers, and full and/or part-time aides, some of whom may be trainees under local manpower programs. Each state-run center also has an outreach worker. Former migrants are represented among both the teaching and paraprofessional staffs in each center.

Based on a recent census of the migrant population in Wayne County by the local farmworker organization, it can be estimated that there are between 700 and 2,000 migrant children in the county. As only 145 migrant children are provided with day care, this low figure indicates that the need for migrant day care is largely unmet. However, many providers reported that this was not the case, and stated that more than half of the migrant day care need was met.

There are, however, political and administrative obstacles that impede program effectiveness. Interagency coordination in general has been difficult, and the State Migrant Day Care Program has had problems with one center concerning quality of care. Officials in the town where the majority of Wayne County migrants live recently declined to continue to provide facilities for a Head Start program. Thus, the program was forced to seek quarters elsewhere, and that portion of the county was left with no day care whatsoever, public or private. Migrant children participating in that program must now be bused up to twenty miles each day to attend existing migrant day care centers. The state migrant program is developing a revised staffing plan for its centers that will free the director from teaching to permit more community contact. The local attitude toward social programs may make it difficult to obtain community support. If so, a perpetuation of the segregation of day care centers and of migrant children from the communities in which they live could ensue; perhaps limiting the numbers and kinds of developmental stimuli the children could receive through field trips, community gatherings, and interaction with adults and other children from different cultural backgrounds. Difficulties with staff turnover in the centers could result in less attention for the children while in the centers, and perhaps a decrease in the interaction a child needs for proper development.

Education

The State Bureau of Migrant Education reports that approximately 1,000 migrant students were enrolled in Title I Migrant programs in Wayne County during 1975-76. As there is a biweekly census of migrant children conducted in New York state, identification of migrant children is relatively thorough and thus the Bureau of Education figure may be accepted as reliable. Programs are operated in six schools and at one regional live-in vocational secondary school in the area. Only settled-out migrants are served at the vocational secondary school as currently migrating students do not stay in Wayne County long enough to be enrolled in this program. At least two of the six schools operate summer programs which run for six weeks and close in time to prepare school facilities for fall classes. Children from preschool age through grade 12 are served by Title I Migrant programs. Some migrant children do not participate in Title I Migrant programs, however, because they arrive just a few weeks before schools close in June or they work in the apple harvest in early fall. Nonetheless, the number of children provided with Title I Migrant Education programs probably approaches 80% or 90% of those eligible.

The educational services offered at the various schools include intensive reading, mathematics, tutoring programs, counseling, recreation, and improvement of self-image. The size of enrollments varies greatly; the largest Title I Migrant program for which information was obtained serves 380 children; the smallest serves 12 migrant children. Three LEAs reported program costs which were $204, $250, and $263 per pupil.

Support services also vary. All of the programs surveyed offer health diagnosis and utilize the Migrant Student Record Transfer System to some degree. Staff of the smallest program reported no difficulties with the MSRTS, but teachers at the other two schools surveyed indicated that the MSRTS provides insufficient data for serving the children adequately. None of these three LEAs offer bilingual/bicultural education, vocational, or breakfast programs. The two smaller LEAs do not conduct outreach/recruitment efforts.

The numbers and types of staff persons vary with the size of the program. The smallest Title I Migrant program employs one coordinator and one teacher. The largest program employs fifteen teachers for its summer program, seven teachers during the academic year, four outreach workers, and ten teacher's aides. Five teachers, six aides, two secretary/clerks, one reading coordinator, and one home-school counselor are employed on a part-time basis to operate a program serving 132 children. The student/classroom staff ratios range from 1:11 to 1:18. It is not known how many former migrants are on the staffs of Title I Migrant programs. One respondent indicated that in the largest program the only non-White faculty member was one teacher's aide. This caused unrest among the large Black student population, which included many migrants.

All of the social service agencies serving migrants in the county indicated they had some linkage with the schools, mostly through receiving referrals from the schools of children or families who need specific help. DSS and the Nutrition Extension Service indicated, however, that few of the referrals they received were migrants.

In conclusion, it is evident that a substantial number of migrant children are being served in the county. However, whether services are provided to this group on a level equitable to others in the county's educational system is not directly ascertainable from this study.

Health

The migrant health clinic in Wayne County is the main out-patient facility for all people in the county. The clinic serves 150 migrant children and 1,000 migrants annually. Funds provided through the Migrant Health Act constitute only part of the support for this clinic. The clinic operation is similar to a group practice as the participating doctors have their own offices in the building and take turns staffing the out-patient clinic. New cases are seen at the clinic and referred to the appropriate doctor for follow-up care on a private basis. The clinic contracts with the local hospital for laboratory work, X-rays, and pharmacy services, and with local opthalmologists for eye care. All severe cases are referred to the hospital. The clinic itself runs an unusually large dental program including emergency, regular, and preventive care. Outreach services of the clinic are rather extensive. The social services staff members try to visit each of more than 100 migrant camps once each season to inform migrants of the clinic services, and remind them of immunization needs. At these visits, contact is made with each family. The clinic provides physical examinations for some of the local Title I Migrant Education summer projects. It is difficult to complete physicals for all children during the six-week program because so many children must be served at once. The clinic has recently become a part of the EPSDT program, which may increase loads to the point where the clinic can set aside one morning a week for screening children.

Although the service area of the clinic includes all of Wayne County, most of the clients served are from the northern part of the county. Because the southern part of the county is without an accessible migrant health clinic and ready transportation to the northern facility is unavailable, there is a gap in health care in the southern half of the county. In one town with a moderately large Spanish-speaking population which includes some migrants, there is a problem in obtaining health care due to the language barrier. The administrator of the clinic thought that migrants not seen at the clinic apparently find their health services elsewhere and have no problems paying for their health care.

Additional health services are provided by the County Public Health Nursing Service. The main functions of this service are to control communicable diseases, serve the disabled, provide in-home care, and operate tuberculosis and immunization clinics. Immunization clinics are provided in the day care centers each season, and lead and sickle-cell anemia screening are also done as part of the physical examination provided at the migrant day care centers. These services for children are the only direct targeted contact the nursing service has with migrants, although many migrants participate in the other clinics for adults. Women's and children's health care is provided through home visits. Parasites and skin problems were reported to be the most common health problems among migrant children. There are no former migrants or bilingual/bicultural persons on the staff, which includes ten nurses and nine paramedics.

The State Department of Health Regional Migrant Camp Nurses Program provides primary and preventive health care and some diagnostic services through regular visits to migrant camps in the county. A team of four nurses, based in the County Public Health Nursing Services office but funded by the state health department regional office in Rochester, operates the program. These nurses provide health care and education in the camps. The nurses visit the three migrant day care centers occasionally, but the program does not permit them to function as liaisons between the day care center and children's homes. The program makes no provisions for transporting migrants from camps to the migrant health clinic.

The Title I Migrant Education programs operated at seven schools in the county also provide health services to migrant children participants. These services are normally handled by the schools' nursing staffs.

There is no coordinating body for migrant services in the county, nor for health services to migrants. As a result, there is considerable fragmentation in social service and health care delivery, particularly with regard to transportation, referrals, and follow-up. The social services coordinator of the migrant clinic and the farmworker organization director called a meeting of all migrant service providers in the county prior to the 1976 farmwork season. Their intention was to develop interagency working agreements to provide transportation to migrants in critical situations. Several respondents reported that no such agreement evolved.

Additional Services

The county agricultural extension service provides a nutrition counseling service to migrants in their communities throughout the county. This is perhaps the most effective outreach to migrants in the county. During the farmwork season, regular visits are made to all camps and other migrant communities. The extension agents also work with the staff and children in the migrant day care centers. The program continues after the end of the farmwork season: five aides, who are migrants, assist in the program and travel back to their home base in Florida with the families. Each aide works with 20 to 25 families during the off-season under a coordinated sister program run by the state of Florida.

Farmworker Organization

Program Funding, Inc. (PFI) is the statewide farmworker organization in New York. It was formed in the late 1960s for the purpose of disbursing U.S. Office of Economic Opportunity funds to the various migrant projects supported by that office. Since that time, PFI, based on its knowledge of these programs and the populations served, has secured additional or alternative funds for many of these projects from other sources. PFI itself is now the grantee for a number of programs. These include the statewide CETA Title III Section 303 Manpower program for migrants, operation of the Title I Migrant secondary level Learn and Earn programs throughout most of the state, and various consulting operations, including management consulting for the state migrant day care program.

In Wayne County, the local PFI office sponsors some job development programs, but the 303 migrant manpower program is operated by CAP. PFI works to identify and assist settled-out migrants, coordinates with the local alcoholism program, and is one of the few agencies in the county which provides emergency food, clothing, and gasoline. It is the only agency in the county that helps newly arrived migrants find emergency housing. Although its resources and services are limited, PFI is a strong advocate for farmworkers attempting to obtain the services and recognition they need.

There is insufficient coordination among migrant service providers in the county. Several respondents indicated specific personal as well as organizational problems in working with agencies providing related services. As a result, during part of the year, the two agencies providing emergency food vouchers were offering them at different rates and were not checking with each other to prevent duplication of service. Coordination is vital with regard to transportation, but there is no coordinated service. As mentioned, a conference to bring provider agency representatives together at the beginning of the season last year to identify means of providing improved transportation and thus more efficient services did not accomplish its goal.

The lack of interagency cooperation emphasizes the need for a functioning council of farmworker services in Wayne County, and at the same time shows why such a body does not exist. Several respondents at the state level indicated that Wayne County was a considerable "sore spot" in their attempts to serve migrants in the state. The fact that the county has the largest seasonal population of migrants heightens the negative consequences of poor coordination.

State Service Provider Agencies

Social Services

The Family Services Division of the Department of Social Services, the state's welfare agency and designated Title XX agency, does not identify migrants within its caseload. At the state level, there is no specific program or information differentiating the needs of migrants and the rest of the population. In the past, DSS has sent a representative to the interdepartmental committee on Migrant Labor, and has had an advisory committee on day care with a subcommittee on migrant day care. The migrant labor committee recently revived, was defunct for nearly two years, and the state migrant day care committee has not met since the program was transferred to the Department of Agriculture and Markets in 1975.

In short, the state Title XX agency has no specific involvement whatsoever with the provision of Title XX or other services to the migrant population. In large part, this is due to the funding structure which supports services to migrants on a nontargeted basis by virtue of their being part of the general population, during their seasonal stays in the state.

Child Care

The New York State Department of Agriculture and Markets has run a day care program for migrant children since the late 1930s, although it was largely custodial until recently. The program, originally the idea of the growers themselves, is contracted out to The Growers and Processors Association which administers it. This association has a board of directors that is responsible for all policy decisions concerning the program, but most operational decisions are made by the Department of Agriculture and Markets office. The role of the growers' association permits the program to operate outside of the state civil service and also permits uniform licensing procedures. The Agriculture and Markets Migrant Day Care office has in recent years benefitted from an unusual amount of attention and support from the Agriculture and Markets hierarchy. This has permitted great improvements in programs, but the improvements are being curtailed as program expenditures have recently begun to exceed allocations.

The program operates approximately 23 centers around the state, each of which provides meals, health care, recreation, and an educational curriculum. Many of the centers function as focal points for the migrant community and provide transportation, outreach, and some social services. Center staff maintains contact with parents and sponsors gatherings and outings for the whole family. In areas of the state where no federal or local migrant day care programs exist, this program constitutes a vital service for the migrant families who come each year to pick the crops. The state migrant day care program is discussed in greater detail in Part Five, Chapter III of this report.

Education

Several operational characteristics of the New York State Bureau of Migrant Education contribute to the unusual effectiveness of this program. This office funds a statewide biweekly census, conducted throughout the year, of all children eligible for the Title I Migrant program. Census results are tallied centrally and sent to each school district that operates a program or has eligible children enrolled. The Bureau is also involved in a number of other programs at the state level to benefit migrant children through the use of Title I Migrant funds other than through local programs. Nutrition education programs are offered through the county agriculture extension service and universities provide recreation programs. Migrant day care center staffing is provided in conjunction with the State Department of Agriculture and Markets which operates those centers. Further, the Bureau maintains a record of the arrival and departure times of each migrant family or group of families for each LEA in the state that customarily operates a Title I Migrant program. These records make it possible to time program preparations appropriately prior to the expected arrival of migrants and to monitor programs so that LEAs which request funds too early or too late in the season can correct their error in time to prepare an adequate program for the migrant children's arrival.

The state Title I Migrant program served 6,818 children in 1975-76. The program operates in 52 New York counties, but over half of the students are served in seven counties. Nineteen counties each served fewer than 25 migrant children in 1975-76. Day care is provided through the partial funding arrangements identified above in 18 of the LEAs; summer programs are operated by 21 out of the 33 LEAs. Schools with Title I Migrant programs served migrant children an average of four months of the year, with children enrolled five to eight weeks. The Title I Migrant budget totalled $2,800,000, and was distributed among 33 LEAs and the State Office of Education.

It was not known how many former migrants were on the local Title I Migrant staffs. LEAs are requested, but not required, to have migrant parents on their Parent Advisory Councils of the Title I Migrant projects. The state office makes use of three staff members, each assigned to monitor the projects in a different region of the state, and an education specialist to oversee curriculum and program development statewide. The Title I Migrant program works in conjunction with the Agriculture and Markets day care program in operating the migrant day care educational components. As a result, there is need for frequent coordination between the two programs. There are informal channels for communication and coordination, but differences persist, such as the housing of a child care program within a state department of agriculture and proper staffing standards for day care programs, specifically the degree to which such standards should parallel those used in schools.

Health

Adequate health care remains a problem for migrant children in New York state as federal funds are scarce. The four migrant health clinics in the state have had their funding reduced by 25% to 40% in the last two years. Federal health funds received through the East Coast Migrant Health Project have been used in the past to provide nurses for the state-run migrant day care centers. These funds were reduced to such an extent that they can support only the salary and travel expenses of the statewide health coordinator to the program. The state has had to provide for the costs of the nurses out of the Agriculture and Markets day care budget.

The structure and diversity of health programs pose some problems for coordination and efficient service delivery. The day care center nurses do not go to the camps regularly as there are public nurses specifically assigned to serve the camps. Unfortunately, these nurses do not coordinate on a day-to-day basis with the day care centers, the migrant health clinic, or the Title I Migrant Education program in the schools, so they are likely to be ignorant of health needs identified by the other agencies. Also, these nurses are under the direction of the regional office of the Department of Health, although they are based in the county health departments.

The state health department currently funds several small auxiliary service and testing/research projects concerning migrants. The budgets of these programs average less than $5,000 each, except for a $45,000 project which provides outreach nurses to migrant camps in 14 counties. The department does not specifically target any of its primary service programs to migrants except for these small projects. The individual charged with monitoring these projects, an assistant to the director of the Community Health Services unit in the department, has many other duties as well. There have been no visits or evaluations of these projects in at least two years. Much of the information concerning their operations was in fact provided not by the project supervisor but by the health specialist of the migrant day care program, who serves as an informal liaison between the Community Health Services unit, the day care program, and the migrant education program.

According to state level health officials, the outreach nurses reached 400 migrant children last year. As regional administration of EPSDT, WIC, and the MCH programs was an obstacle to providing service, state program administration might exert greater influence on the counties to provide better service delivery. Perhaps this would facilitate a more rapid response to health needs when the migrant season begins. More health education is needed. The Sanitation division of the Health Department is greatly concerned with migrant housing conditions, but there has never been any coordination between Community Health Services and the Sanitation division with regard to migrants.

CHAPTER X

NORTH CAROLINA: JOHNSTON COUNTY

Agriculture is a major industry in North Carolina; nearly half of the land in the state is devoted to farming. The agricultural sector of the state economy depends in part on the labor of migrant and seasonal farmworkers. The migrants who work in North Carolina are part of the East Coast stream, and the majority of interstate migrants there have their home base in Florida or Mississippi. There are Blacks, Whites, Hispanics, and Native Americans among the migrant population in North Carolina. The composition of the migrant population is somewhat unusual since the proportion of Hispanic people is low and North Carolina is the only state in which Native Americans comprise more than 1% of the migrant stream (USDA, "Migrant Farmworker," p. 11). In the past three years, the number of migrants in the state has increased greatly. State agency officials reported that in 1947 there were an estimated 9,000 migrants in North Carolina; projections indicate that there will be 18,000 migrants in the state in 1977. Migrants form part of a large group of poor people in North Carolina. Census figures from 1970 indicate that there are 212,000 poor families, or more than 990,000 poor people, in North Carolina.

Johnston County, located in the central eastern part of North Carolina, was identified as the county with the highest number of migrants. The population of the county was 61,737 in 1970. In 1976, estimates of the numbers of migrants in the country averaged 4,500, but the migrant population during the peak season was estimated as 6,000. The major crops in Johnston County are corn, Irish potatoes, pickle cucumbers, soybeans, sweet potatoes, and tobacco. The cultivation of soybeans makes for a long harvest season in Johnston County, since soybeans may be picked from March 1 until November 1. The peak of the harvest season is from July to September. Other counties in North Carolina have equally long harvest seasons. For the most part, these are the soy-growing counties located in the eastern part of the state slightly inland from the coast.

The major providers of child welfare services in Johnston County are the Migrant and Seasonal Farmworkers Association, Inc. (MSFA), a farmworker organization, and the Sampson-Johnston Migrant Health Clinic, a private organization backed by public funds granted under the Migrant Health Act. Other organizations which attend to the needs of migrant children include the county departments of social services and health, and the local schools.

Services and Needs in Johnston County

Social Services

Social services are administered by the Johnston County Department of Social Services (DSS). Child welfare services provided in Johnston County are adoption, contracted day care, foster family care, homemaker services, protective services, and family planning. Under Title XIX, Medicaid, EPSDT services are also available.

In North Carolina, the responsibility for planning local Title XX programs rests with the county governments. These bodies, acting as autonomous units, determine both the types and the extent of child welfare services to be provided through purchase on the local level within their respective jurisdictions. County governments are also responsible for helping to organize the social services delivery system and for adapting that system to programming changes. The county board of social services reviews, modifies, and approves the budget for social service programs planned at the county level, and the county commissioners then levy the taxes to meet the budget. Since county taxes constitute a significant portion of the Title XX budget in North Carolina, the planning and budgeting of social services is likely to undergo careful scrutiny at the local level.

Eligibility requirements for the Johnston County DSS programs are the same for migrants and nonmigrants, and department staff reported that all migrants are eligible for services. There is, however, a broad difference between the numbers of migrants and nonmigrants reached by DSS child welfare services. Between July 1975 and June 1976, no migrant children were served by adoption or day care, while 63 nonmigrant children were reached by these same programs. In the same time period, a total of 13 migrant children and 687 nonmigrant children were served by foster family care, homemaker services, protective services, and family planning. The maximum number of migrant children reached by any single Johnston County DSS program was four. There is no staff member assigned to deal specifically with child welfare among migrants. The DSS staff does not include either former migrants or bilingual or bicultural people.

Funding for Johnston County child welfare programs is derived from federal, state, and county funds combined, and the amount of funds available is contingent upon the program and budget as approved by the county commissioners. A profile of the North Carolina child welfare delivery system indicates that, as of December 1975, some counties had difficulty generating the nonfederal matching funds for Title XX services (U.S. Department of Health, Education, and Welfare, "Child Welfare in 25 States: Profile of North Carolina," p. 9). This would seem to be the case in Johnston County.

Staff members of the Johnston County DSS reported that migrants go to the farmworker organization for services. MSFA services do not duplicate those of the DSS. Since DSS contact with migrant children is minimal, the needs of migrant children for the types of services provided under Title XX are not being met. In fact, a DSS staff member reported that the county office is meeting only a small part of the needs of all children.

Outreach activities were identified by county personnel as a major need in providing social services to migrant children. It was suggested that outreach could be facilitated by naming one person to be responsible for working directly with migrants, hiring a bilingual staff member, and alleviating the transportation difficulties which hinder service delivery to migrants.

The DSS is involved in some coordination activities. It takes part in monthly meetings of the local migrant advisory council which brings together public and private service agencies, the farmworker organization, and county officials. This council works to coordinate services and avoid duplication. It appears that, in practice, the interagency coordination achieved by the council is limited if not weak. The only formal interagency linkages maintained by DSS are with the county health department and local schools. There is no coordination with the migrant health clinic, and the DSS linkages with the farmworker organization and community action program consist solely of receiving referrals for social services delivery. short, at the administrative level, DSS contacts with migrants are limited just as they are at the services delivery level.

The Johnston County DSS has no activities related to program development in the area of migrant child welfare. The staff members have not participated in training programs concerning services to migrant children.

The private sector also provides some social services in Johnston County. The local community action program (CAP), Johnston County Community Action, Inc., offers social services but does not operate any programs which serve migrant children.

Child Care

The sole provider of day care for migrant children in Johnston County is the Migrant and Seasonal Farmworkers Association (MSFA). No programs exist for before- or after-school care of school-age children. Infants and toddlers are not served by the day care programs currently available in Johnston County. Although the local DSS provides day care and the local CAP operates a Head Start program, migrant children are not served by these programs.

Since MSFA does not operate its own day care centers, it provides services statewide by purchasing slots at licensed centers. In Johnston County, MSFA funds 20 slots at the Child, Inc., day care center located in Smithfield. In the fall of 1976, there were 6 migrant children, of a total enrollment of 28, attending Child, Inc. This center is not licensed to care for infants, so only those children between the ages of 3 and

6 are served. During the summer, children up to 13 years of age may enroll at Child, Inc. The center operates from 8 a.m. to 4 p.m. five days a week throughout the season when migrants are in the area. The curriculum at Child, Inc., includes the alphabet, shapes and sizes, hygiene, songs, and rhymes. The day care program includes various supportive services such as free meals, referrals of migrant children for physical examinations, and transportation to and from the center. The six-person staff of Child, Inc. does not include former migrants.

Migrants and former migrants are heavily represented on the policy-making board of Child, Inc. Ten of the fifteen board members are migrants or former migrants. Management of the day care program includes coordination with the migrant health clinic and the MSFA. Some efforts have been made in the area of program development. Three of the six staff members--the director, the teacher, and the cook--attended a two-day training workshop on the nutritional needs of children.

There are a number of problems in delivery of day care to migrant children in Johnston County. Personnel at a variety of agencies underscored the need for day care for infants and toddlers since currently there are no programs whatsoever for children under three years of age. An additional problem is the lack of after-school care for school-age children. The day care facility at Child, Inc. is inadequate in that it lacks a playground. The center is also in need of another vehicle in order to provide transportation for all students.

Education

In Johnston County, four local schools participate in the Title I Migrant Education program. Some schools in which migrant students are enrolled did not receive Title I Migrant funds in fiscal year 1976. The only educational program run exclusively for migrants is the five-week summer school which provides instructional and support services, including an immunization program. Migrant students enrolled at public schools during the regular academic year participate in the standard curriculum activities, and tutorial services are available at schools which have high concentrations of migrants in the student body. The migrant summer school and all other educational support services are federally funded.

Title I Migrant Education programs served 331 migrant children in Johnston County with a budget of $57,148 during fiscal year 1976, an increase from the 250 served with a budget of $44,138 during fiscal year 1975. The 1976 summer school program served 110 migrant children. The summer school for migrant children includes breakfast and accident insurance for all students, immunization which reached 50% of the students, and social worker services which reached 30% of the enrollment. Support services for migrant students during the academic year included health diagnosis and treatment, psychological counseling, and outreach/recruitment. The impact of health and counseling services is limited, however; it was estimated that these services reached 10% or less of the children. Outreach/recruitment services were said to serve 100% of the school children.

The summer school program for migrant children employs six teachers, six aides, one social worker/nurse, one coordinator, and three cooks. During the regular academic year, Title I migrant staff includes one coordinator, who is also a home-school liaison, and four tutors.

Local educational officials judged the Migrant School Record Transfer System (MSRTS) to be effective as a means of providing continuity in educational and health services for migrants. A number of problems have arisen in utilization of the MSRTS, such as delay in receiving records, lack of grade placement, changing of numbers assigned children due to changing of names or birthdates, and lack of a uniform criterion mathematics and reading test.

Health

The providers of health care to migrant children in Johnston County are the Sampson-Johnston Migrant Clinic, which serves Sampson, Johnston, and Harnett counties, and the Johnston County Health Department. The migrant clinic is a new organization established in June 1976. It is located in Newton Grove, some 30 miles from Smithfield where the county health department facilities are based. The county health department only serves migrants who are referred by the migrant clinic. This procedure and the distance which separates the two facilities hinder health service delivery to migrants. The Sampson-Johnston Migrant Clinic is funded by a grant of $67,203 from the U.S. Department of Health, Education, and Welfare.

Since its founding, the Sampson-Johnston Migrant Clinic has been the major provider of health care to migrants in Johnston County. All migrants are eligible for services at the clinic upon proof of migrant status. The services provided to migrant children are dental care, immunizations, physical examinations, tuberculosis screening, outreach, and follow-up. Physical examinations are given to six-week-old infants and to school children. Prenatal care is provided at the clinic and has reached several migrant mothers. Health related services provided through donations arranged or made by the clinic staff include the distribution to migrants of food, clothing, and hygiene supplies. Between June and November 1976, 499 migrant children, and 2,300 migrant adults were served at the clinic. The clinic offers a number of special services, such as night clinic, providing immunizations, interpreter services, and some transportation between the migrant camps and the clinic. Without these services, migrants' access to health care would be severely limited.

The migrant clinic meets almost all needs for care of sick migrant children and keeps virtually all migrant children in the area up to date on immunizations. The care of sick children involves treating upper respiratory infections, parasitic infestations, anemia, impetigo, ear infestations, and nutritional problems, as these are the most common illnesses among migrant children in the area.

The major problem in delivery of health care to migrant children is the provision of preventive health care and well-child care. Crew leaders present an obstacle to the delivery of these services since they do not allow migrant parents to take their children to the clinic unless the child is observably ill or injured. Also, parents often do not take their children for well-child care since this often requires taking time off from work. As elsewhere, transportation problems interfere with health service delivery to migrant children and to migrants in general. Although the farmworker organization provides transportation for getting migrants to the clinic, these services were reported to be insufficient for meeting the need. As a result of these difficulties, treatment administered to migrant children and farmworkers at the Sampson-Johnston Migrant Clinic is usually emergency or crisis-oriented rather than preventive.

The migrant clinic facilitates access of migrants to medical and health-related services not provided at the clinic. Migrants are referred to the county welfare department for eyeglasses and food stamps. The migrant clinic maintains contracts with county health departments for chest X-rays and tuberculosis drugs and with private doctors for specialized care. Migrant women, infants, and children are referred to the county health department for the WIC nutrition program. In case of serious illness, migrant children are referred to a hospital.

There are a number of difficulties involved in referrals and contracts with other health providers. Payments to contracted doctors can be delayed by paperwork, private doctors can be slow in reporting the outcome of their visits with patients, and migrants are not always able to meet the fixed appointment times set by private doctors. By late 1976, the clinic had exhausted its funds for financing referrals to private doctors. Referrals to the local and county health departments and the WIC program are complicated because the Sampson-Johnston Migrant Clinic serves migrants from various counties and it may be difficult for migrants to meet the eligibility requirements for obtaining services provided through the county health departments. Referrals of children to hospitals require the consent of a parent or guardian which has been difficult to obtain when the parent was far away from the clinic. Transportation difficulties and language barriers limit the effectiveness of referrals just as they affect all aspects of health service delivery.

There are no former migrants on the staff of the clinic, but the staff members are familiar with the culture of migrants and of the local area. The clinic has one bilingual interpreter who helps with transactions at the clinic and assists in providing outreach and transportation services.

Outreach services are handled primarily by the MSFA, and include transportation to the clinic. Clinic staff members or interpreters occasionally go to the camps to see that health care is provided, and some medical counseling and follow-up services are available. There is no health education program at the clinic.

The Sampson-Johnston Migrant Clinic staff works to assure continuity of service and follow-up health care by requesting health records on its clients from the area where they last lived and by referring migrants to health programs in areas where they will next live. Referrals for follow-up care or additional health services are made and handled locally while the migrants remain in the area.

Program management activities of the migrant clinic include linkages with a variety of agencies. The state health department provides the clinic with funds for in-patient health care and donates supplies to the clinic. The majority of linkages between the migrant clinic and other agencies are based on referrals from the clinic to health care providers. Physical examinations and immunizations are provided by coordination of the migrant clinic with the local schools. The local community action program donated blankets to the clinic.

A number of problems adversely affect the delivery of health care by the migrant clinic. Funding is inadequate and, as a result, the clinic is understaffed and overworked, it cannot finance referrals to private doctors or for hospitalization, and it cannot provide adequate outreach services or a health education program. There are no funds for heating the clinic, and this may aggravate the symptoms of ill clients, children and adults alike. Referrals are complicated by the fact that the Sampson-Johnston Migrant Clinic serves a three-county area while other providers serve only migrants within their county. Also, the clinic staff must determine the eligibility of migrants in order to refer them to other providers, while the clinic itself has no eligibility criteria other than proof of migrant status. There are difficulties in obtaining reports of results of health care provided on a referral basis. The major problem with health care provided to migrant children at the Sampson-Johnston Migrant Clinic is that treatment tends to be crisis-oriented rather than preventive. The delivery of preventive and well-child care is blocked by the attitudes of crew leaders and parents and by the lack of outreach, health education, and transportation. Certainly an increase in day care facilities would improve the possibilities for providing preventive and well-child care and health education because the clinic could coordinate such services with the day care providers.

Despite the many problems which have an adverse effect on health service delivery, health care provided by the Sampson-Johnston Migrant Clinic does reach a majority of migrant children in Johnston County and is probably the only county welfare service which reaches large numbers of migrant children. Staff members at the clinic feel that most of the significant problems in health service delivery could be alleviated through increased funding which would make it possible to hire more staff and thus expand services.

The Johnston County Health Department offers a full range of health services, but treats migrants only when they are referred by the migrant clinic. In effect, then, the county health department is only a supplemental health care provider for migrants. Eligibility for county health department services is determined by residence and income criteria, and all migrant children referred for health care were found to be eligible for services. In fiscal year 1976, only 11 migrant children were served by clinicians and outreach services, which consisted of home visits to the camps. The cost of the clinicians' services was $1200. Migrant women and children can benefit from the WIC program run by the county health department if, again, referred from the migrant clinic.

Coordination with other service agencies and contracts with health care providers are the primary program management activities of the Johnston County Health Department. There is close coordination of service delivery between the county health department, the Sampson-Johnston Migrant Clinic, and the local schools. The county health department, along with MSFA, the state health department, and the local community action agency, participates in the regular meetings of the Migrant Advisory Council. The county health department has contact with migrant camp owners prior to the arrival of migrants.

A number of factors restrict the effectiveness of the Johnston County Health Department as a provider of health services to migrants. There are no bilingual persons or persons knowledgeable about the special problems of migrants on the staff, the funds available for contracting services such as private medical attention or hospitalization are insufficient, and follow-up is difficult due to the use of third-party reimbursement and the mobility of migrants. Two members of the health department staff perceive the major problems in providing health care to migrants as being lack of funds and difficulty of follow-up.

Farmworker Organization

The farmworker organization in North Carolina, the Migrant and Seasonal Farmworkers Association, Inc. (MSFA), has been in existence for over ten years and also operates in Virginia and, since 1976, in Maryland. The primary purpose of MSFA is the economic upgrading of migrant farm laborers to facilitate their settling out of the migrant stream. To this end, the organization administers vocational classroom and on-the-job training programs, work experience, manpower services, and support services. MSFA does provide some child welfare services, most notably contracted day care and support services, but such programs are not included among MSFA priorities. Any migrant other than an illegal alien is eligible for MSFA services. MSFA is predominantly a Black organization but also serves many Chicano migrants.

MSFA personnel judged child welfare services in North Carolina to be inadequate. It is felt that the federal government carries the major responsibility for migrant child welfare at present and that the state should take on a greater role in providing migrant child welfare services. MSFA staff members expressed the opinion that the only state programs that assist migrant children are those administered by the state health department and through Title I Migrant Education funding. The state is believed to have the resources to provide more servicesthan it presently does for migrant children, and it is felt by MSFA staff that more involvement at the local level would lead to better services and greater utilization of resources.

Migrant child welfare services in North Carolina are affected by a number of factors. As elsewhere, funding shortages, the distance between migrant camps and service providers and the operating hours of service agencies hinder service delivery. In addition, many children work in the fields, so services do not reach them through programs for children. Proposed solutions to these problems include increased funding and staffing for child welfare programs. The expansion of day care services of all types would help alleviate the child labor problem and would facilitate child welfare service delivery.

MSFA staff members indicated that migrant children are discriminated against in the provision of child welfare services, but also noted that children from low-income families in general are lacking in services. They felt that a greater sensitivity to the economic significance of migrant labor would help alleviate the problems posed by discrimination. MSFA is involved in a variety of activities aimed toward publicizing the issue of migrant child welfare in North Carolina. Staff members participate on boards and at meetings which deal with child welfare, give speeches to church and civic groups, arrange for press coverage, and currently are producing a film about migrant child welfare.

MSFA is involved in coordination activities at the local and state levels. Its representatives participate with local public agency staff members and county officials in the monthly meetings of the Johnston County Migrant Advisory Council. The State Advisory Committee on Services to Migrants, a voluntary organization, meets bimonthly. Its membership includes representatives of more than 20 federal, state, and private service providers. The purpose of these organizations is to coordinate services and resources and resolve mutual problems.

State Service Provider Agencies

Social Services

As the administering agency for Title XX programs, the Department of Human Resources (DHR) is the major provider of social services in 100 North Carolina counties. DHR is an umbrella agency which determines eligibility criteria for Title XX social service programs but does not provide direct services. North Carolina is one of twelve states in which social services, including child welfare programs, are administered at the county level; the state provides funds and acts as a supervisor, consultant, and evaluator for county-level social services delivery. Funding of Title XX services is derived from federal, state, and local monies; in fiscal year 1976, the federal government contributed 75% of the budget, the state 7%, and county governments 18%. As of July 1976, the state was utilizing 66% of the federal share of Title XX allocations. The remaining Title XX federal funds were not utilized because state and county matching funds were not raised.

Statewide, 31 social services are provided. Eligibility for services is dependent upon citizenship and income level, as follows: all services are available to people with less than 65% of the median income; fewer services are available to people with 80%, and still fewer services are provided to people earning 100% of the median income. In accord with Title XX policy, North Carolina provides protective services and information and referral free to all people regardless of income.

The services available vary from county to county since the type and extent of services provided are determined by the county government as part of the planning process for Title XX programs. The major constraint imposed on county autonomy in the provision of services is that state or federally required social services are top priority and must be available statewide. The primary opening for the exercise of county autonomy is the provision that optional social services are to be prioritized by the county planning process; that is, additional services may or may not be provided.

Because the state DHR is not involved in service delivery, its activities are limited. The DHR does not have contracts with service providers and does not operate or contract staff training programs. The DHR does not give any special attention to migrants on a statewide basis. Neither DHR records nor the state child abuse registry identify migrants as a subpopulation. A staff member reported that DHR is doing "nothing" to increase public awareness of migrant child welfare. The fiscal year 1977 Comprehensive Plan for Title XX services does not include a special line item for migrants or migrant children, nor does it name migrants as a target group for Title XX goals and programs. The true measure of services to migrants in North Carolina is service delivery at the county level. As seen, social services for migrants in Johnston County are severely lacking.

The DHR coordinates with other agencies that provide services to migrants. The major vehicle for coordination is the State Advisory Committee on Services to Migrants, the purpose of which is to ensure coordination of services to migrants, to consider and resolve shared problems in service delivery, and to assist local communities in forming and maintaining active advisory committees.

The DHR, through the county departments of social services, is the sole provider of child welfare services to migrant children in North Carolina. A statewide voluntary organization, children's Home Society of North Carolina, does provide welfare services to children, but has no programs for migrant children.

Several serious problems affect the delivery of social services in North Carolina. First, services are limited because the state does not utilize the full federal allocation of Title XX funds due to the fact that the state and the counties do not raise sufficient matching funds. This may indicate that social services are considered a low priority within the state. County autonomy in determining the availability of certain social services can, and sometimes does, mean that some services are not offered. The constituency for social services in North Carolina is extensive due to the high numbers of poor people. The migrant population in the state has virtually doubled in the last few years. The need for social services is great and, at the same time, places a strain on currently available resources.

Child Care

In North Carolina, the major provider of the day care to migrant children is the Migrant and Seasonal Farmworker Association. The farmworker organization does not operate day care centers but provides day care to 107 migrant children statewide through the purchase of slots at seven private day care centers. Each center serves an average of 15 migrant children during the year and 25 migrant children during the peak season. All the migrant children enrolled by MSFA in day care centers participate in standard preschool educational activities and are also provided with support services which include health diagnosis, immunizations, and meals. In addition, 70% of the MSFA sponsored children were covered by the Medicaid EPSDT program.

The day care services provided by MSFA are deficient in a number of ways. The hours of operation at day care centers do not match the working hours of migrant parents and so children are left unattended or in the care of older siblings during part of the day. In general, there are few facilities for providing care to infants and toddlers less than three years of age. Some of the MSFA contracted centers have inadequate transportation services, so access of migrants to day care is hindered. Lastly, the resources of MSFA for providing day care do not nearly meet the migrant need.

The Department of Social Services provides day care to 8,700 children statewide through contracts, direct vendor purchase, or centers operated by county level departments of social services. Since migrants are not identified as a subpopulation, it is impossible to determine how migrant children are served by DSS day care programs. Throughout North Carolina, there are 425 certified day care centers eligible for federal funds and between 1400 and 1800 licensed day care programs. These facilities are very unevenly distributed in the state. State level DSS employees report that the eastern part of the state has virtually no day care services. The migrant population in North Carolina is heavily concentrated in the eastern region, precisely where day care is lacking. Johnston County is also in this area. It is hard to support day care centers in the eastern part of the state because the area is rural, sparsely populated, lacking in large cities, and much of the day care need among local residents is met through arrangements between relatives or neighbors. To serve the migrant population, day care is needed on a seasonal basis. A major difficulty in operating seasonal programs is that start-up funds are needed each year. Funding regulations do not permit the state DSS to provide start-up monies to centers that are operated by third parties. To date, DSS has not itself operated seasonal centers in the eastern part of the state. DSS employees point out that day care services for migrants are lacking in the eastern part of the state due to local prejudices against migrants. There is a general lack of interest in providing day care to the population at large because people in this area feel that women should not work but rather should stay home and care for the children. The state-level DSS is presently working to develop certified day care programs in the eastern part of the state.

Title I Migrant Education provides day care services in the summer only. In 1976, 66 four-year-olds and 355 five-year-olds were served by Title I Migrant summer preschool programs. Technically, five-year-old children are not considered as day care clients because a recent North Carolina law requires that these children be placed in educational programs (kindergarten) and thereby supplants the need to provide preschool day care services to this group of children.

Education

Title I Migrant Education programs serve migrant children ages 5 to 21 enrolled in grades kindergarten through 12. The State Migrant Education Office, a unit of the North Carolina Department of Public Instruction, is responsible for the coordination of Title I Migrant programs throughout the state. Title I Migrant Education in North Carolina includes summer sessions offered exclusively for migrants. The duration of these sessions is established at the local level according to need, and varies from five to eight weeks. Summer programs cover mathematics and bilingual reading, writing, and speaking. The hours of summer programs are usually from 8:30 a.m. to 3:30 p.m. These hours do not match the working hours of migrant parents. During the regular school year the program consists of providing additional personnel to work directly with migrant children or to free the teacher to work with them. In this way, Title I Migrant Education offers supplemental educational services which focus on basic skills, reading and mathematics, and are taught on a one-to-one basis or in small groups.

There is no priority set on serving any specific age group since the Title I Migrant state program emphasizes the need to serve all school-age children. In North Carolina, Title I Migrant programs do not provide preschool programs for children under five years of age except on a limited basis and only during the summer.

All migrant school-age children are eligible for Title I Migrant programs in North Carolina and also participate in the standard school curriculum. MSRTS statistics indicate that, during 1975-76, a total of

7,385 migrant students participated in Title I Migrant programs throughout the state. This total represents an increase in the size of the program since 6,360 students participated during the 1974-75 academic year. Summer programs are offered exclusively for migrants in 28 school districts and reach 4,000 migrant children. It is estimated by Title I Migrant staff that 95% of the migrant children in North Carolina are served by the educational programs. The majority of children served are of elementary school age since older children tend to leave school and join the work force. Programs for secondary school students have flexible hours to accommodate these students, and the curriculum includes basic skills and vocational guidance. Staff members feel that the MSRTS functions effectively as a means of counting children enrolled. They indicated that the student's academic history information should be more specific, especially in the areas of reading and mathematics skills. The MSRTS information on the health status of migrant children is perceived as the strong point of the record-keeping system.

All support services for Title I Migrant programs are not available statewide. All of the migrant students receive health screening, social worker, and outreach services. Ninety percent of the migrant students are served by the breakfast program, and dental care and medical treatment are provided to half of the students. Additional support services, such as psychological and career counseling, vocational programs, and day care, are not offered by Title I Migrant programs in North Carolina. It was impossible to determine whether the Title I Migrant personnel included bilingual persons or former migrants because the state office does not record such information.

The State Migrant Education Office is responsible for coordinating Title I services to ensure that equal services are provided to migrant children in each county. This activity is carried out through individual monitoring visits which have shown that the quality of the programs does vary from county to county. Representatives of the State Migrant Education Office participate in the State Advisory Committee on Services to Migrants. These representatives report that coordination efforts are quite effective. The state farmworker organization coordinates directly with Title I Migrant programs by providing teacher's aides for the school-year and summer programs, and offers supplementary services such as emergency food and day care. Migrant parents participate in planning and evaluating Title I Migrant programs through local-level and state-level Parent Advisory Councils.

The major program development activity of Title I Migrant Programs in North Carolina is staff training. The state office sponsors statewide and regional staff development sessions for professional and nonprofessional personnel. Throughout the state, Title I Migrant programs are expanding in size and, project staff report, improving in quality.

Title I Migrant programs are not meeting the educational needs of all migrant children in North Carolina. The 1977 application for Title I Migrant funds assessed the educational needs of migrant children in North Carolina and stated, "the greatest unmet educational needs of these children are language arts, reading, mathematics, science, social science, cultural arts, occupational education, arts and crafts, physical education and kindergarten" (North Carolina, Department of Public Instruction, "Application," p. 7). State-level staff members maintain that more monies are needed to meet the needs of migrant students in North Carolina. The farmworker organization reports that a majority of the migrant children work in the fields, which also presents a formidable obstacle to the delivery of educational services.

There are no Title VII Bilingual Education programs in schools in North Carolina. There are several possible explanations for this lack. One factor is that North Carolina is one of the few states with restrictive legislation which requires that classes be taught only in English in both public and private institutions. Federal legislation governing bilingual education requires local educational agencies to make application for funds. State-level migrant education staff members indicated that local schools have difficulty applying for Title VII programs, and this may also contribute to the lack of programs.

Health

In North Carolina, the primary responsibility for delivery of health care lies with the state Division of Health Services of the Department of Human Resources. A variety of health care providers serve migrants in the state. The North Carolina State Migrant Health Program, a unit of the Division of Health Services, is the major provider of health services to migrants in the state and serves 2,000 migrant children statewide through the operation of seven migrant clinics. The county health departments of the DHR are the major providers of health services and referrals to migrants in those areas with migrant populations too small to sustain Migrant Health Program clinics. Eligibility criteria for health services follow federal guidelines and apply equally to migrants and nonmigrants. Locally administered migrant clinics, federal grantees, provide health services in Johnston, Sampson, Harnett, and Henderson Counties. A unique aspect of health care in North Carolina is that the state has allocated funds to finance hospitalization for migrant children.

The North Carolina State Migrant Health Program administers seven migrant health clinics located in seven counties which have high concentrations of migrants. Each clinic provides health care to a specified service area, i.e., a clinic may provide services in several counties. These clinics are supported with state funds and federal funds disbursed through the Migrant Health Act. The program staff includes a program manager, health educator, and field staff at each clinic. In fiscal year 1976, state-provided funds for hospitalization of migrants totalled $72,000 and served 70 migrant children through the migrant clinics. The state Migrant Health Program coordinates health services within the DHR and with other agencies. In this way, migrants gain access to services such as vocational rehabilitation, specialized health treatment, learning disability and crippled children programs, provided by the Division of Health Services. In addition, migrants and their children are served by health programs of other public and private agencies through the coordination of funding of the Migrant Health Program.

Most clinic care of migrant children centers on the treatment of upper respiratory infections, gastroenteritis, malnutrition, rashes, and dental problems, as these are the health problems most commonly found among migrant children in North Carolina.

The seven state administered migrant clinics provide direct services to all migrants and provide comprehensive care through coordination and referrals to county health departments, local schools, and other agencies. Each clinic is staffed by a health team which includes nurses, outreach workers, and physicians. The location and the evening hours maintained by the clinics facilitate access to and utilization of health services by migrants. Various health services, such as dental and emergency care, are not available at the migrant clinics but the clinics provide migrants with referrals and absorb the cost of such services. Outreach and follow-up health care consist primarily of visiting the migrant camps, and are handled by the nurses and outreach workers on the migrant clinic health teams.

The Migrant Health Program operates a mobile health clinic in Duplin, Wayne, and Carteret counties to supplement the services provided by the Carteret migrant clinic and the Duplin and Wayne county health departments. Isolated rural areas in these counties are the home base for many North Carolina migrants and the permanent residence of large numbers of settled-out migrants. The mobile unit enhances the accessibility of health services to migrants in those areas. Maintenance problems have hindered the operation of the mobile unit, effectively curtailing its usefulness.

Migrant Health Program staff members estimate that the program reaches 80% of the North Carolina migrant population with direct services which include preventive care. The in-patient hospitalization service for migrant children is felt to be a program of significant impact. This state-supported service, however, lacks sufficient funding to guarantee service on a year-round basis. Health services provided by the Migrant Health Program are affected by various needs. Staff members feel that more federal funding is needed to improve preventive health care and to provide dental care. Title XX is not considered an effective funding source for delivery of health services to migrant children because too much documentation is required and, as a result, resources which could be used to provide health services are utilized instead for paperwork. Migrant Health Program staff members feel that the interstate referral system for migrants is inadequate and needs to be improved in order to ensure effective follow-up and continuity health care. An additional problem is the rapidly increasing population of migrants in North Carolina which strains current health care resources.

The Sampson-Johnston Migrant Health Clinic and the Henderson County Migrant Health Project are responsible for delivery of health care to migrants in Sampson, Johnston, and Henderson Counties. These clinics are administered locally, operating independently of the state government under federal grants. Migrant families and individuals may be referred by these clinics to other health service providers, such as the county health department, programs at local schools, private physicians, etc., for care not provided at the clinic.

County health departments are the other providers of health services to migrants in North Carolina. In areas served by migrant clinics, the county health department functions primarily as a provider of supplemental services. In areas which have no migrant clinics, the county health department is the major provider of health services and offers comprehensive care through its clinics, coordination with other providers, and referrals. Throughout the state, the county health department is responsible for administering the WIC program. In fiscal year 1976, WIC served 53 migrant children out of a total of 16,255 clients statewide. The number of migrants benefitting from the WIC program is extremely low.

As in other states, primary health care is available to most migrants in North Carolina. The need for preventive care and specialized services, such as dental and eye care, is generally not met by current programs. Significant obstacles remain that hinder the effective delivery of even primary care; these include transportation and funding difficulties, language barriers, and inadequate outreach services.

CHAPTER XI

TEXAS: CAMERON, HIDALGO, AND WEBB COUNTIES

Texas, with the largest population of migrant farmworkers and their families, is the primary home base state for migrants in this country. According to the 1976 census of the Governor's office, 376,000 migrants live in Texas in the winter and consider it their permanent home. This represents over one-third of all migrants in the United States. The largest migrant concentration is in the extreme southern part of the state along the Rio Grande river just west of its juncture with the Gulf of Mexico. This area, known as the lower Rio Grande Valley, contains several major metropolitan areas, many small towns, and smaller clusters of homes, called "colonias," stretching along the river. The portion of the valley that is heavily inhabited by Spanish-speaking migrants, nonmigrants, rural poor (many of whom are seasonal farmworkers), and other lower-middle class persons, extends from Brownsville, near the Gulf, inland to Rio Grande City, about 150 miles upriver. Laredo, the county seat of Webb County, farther up the river, also has a migrant population. Migrants live in the Winter Garden area around Crystal City and in San Antonio, Corpus Christi, and Lubbock. There are a number of families who migrate intrastate, between the Rio Grande Valley and the Lubbock area.

Migrant streams moving north to other states have very specific points of origin. Whole towns in the Rio Grande Valley shut down in the springtime, board up their houses, and head north to a common destination. The predictability of these patterns is not generally recognized, and to a certain extent is subject to other factors such as work availability and weather conditions, but it is common for families who winter in Mercedes, Texas, for example, to be contacted by friends without delay through local farmworker organizations in Fort Lupton, Colorado, in the late spring or in the Yakima Valley of Washington during the summer.

According to the 1970 census, the population of Cameron and Hidalgo Counties was 321,903 persons: 78%, Mexican American; 21%, White; and 1%, Black. Federal expenditures were $313 million in these two counties in 1975, slightly less than $1,000 per person; this large influx of funds is an indicator of the economic depression of the area.

Although the valley supports farming, light industry, shipping, and tourism, unemployment is above the national average. There are many retired but unemployed persons in the valley; in addition, the already high amount of local unemployment is increased in the winter months when the migrant farmworkers return to their home base. Although migrant seasonal farmwork is considered in computing unemployment rates, migrants usually are not covered by unemployment insurance and often must rely on their migration earnings to help sustain them during the off season.

All three survey counties have substantial social service networks with active Community Action Agencies and farmworker organizations offering information and referral services, manpower training, tutoring, day care, education programs, and Food Stamps application processing. Each county has health department clinics and a migrant health clinic, with some formal linkage to the county department; each has welfare offices in major towns and cities.

Two unique programs are operated by one of the farmworker organizations. Both programs involve services for migrants and their families while in Texas and while they go through the northern states on their migrations. Funded by the HEW Office of Child Development, these projects provide preschool educational services under the Head Start program, and child abuse and neglect casework services under a grant from the National Center on Child Abuse and Neglect, working with the Protective Services division of the state public welfare agencies in Texas and the other states through which migrants travel.

Services and Needs in Cameron, Hidalgo, and Webb Counties

Social Services

Many agencies in south Texas supplement the work of the Texas Department of Public Welfare (DPW) in providing child welfare services, day care, and financial assistance. For instance, Catholic Charities, a large, multi-faceted organization sponsored by the Diocese of the Catholic Church in Cameron County, provides a large range of services, including health care, counseling, and day care in the lower Rio Grande Valley, through its own offices and contractual arrangements with other organizations.

The Department of Public Welfare operates on a regional basis in Texas, with small offices in each town, primarily for processing Food Stamps applications. Migrants are a major portion of the case load for food stamps, which are very widely used in this region due to the depressed economy. However, the DPW does not, at state or local/regional levels, identify migrants in its records, so numbers served cannot be presented. Respondents indicated that the malnutrition characterizing the service population in the Valley several years ago has been largely eradicated due to the Food Stamps program, but there are still many other service needs that are not fully met. EPSDT screening and treatment, now provided only to children in AFDC families, is needed, and the health service network is inadequate.

One significant program which directly serves the migrant population is a project funded by the National Center on Child Abuse and Neglect, of the HEW Children's Bureau. This project permits the Texas Migrant Council, as grantee, to develop a working relationship with state DPW workers who are handling cases of child abuse among families known to be migrants. When the family leaves for the season, the TMC caseworkers go on the stream with them, so that they will be accessible if further incidents develop upstream. In 1976, TMC workers served 30 known cases and counseled many other migrant families. While the Protective Services Agency of the state in which the incident occurs has first jurisdiction, TMC has briefed representatives of these protective services staffs on the project, requesting that cases be turned over to TMC for handling, due to their familiarity with the cases and their cultural and linguistic similarities to the families involved. These workers have been on hand in DPW offices in the valley for much of the past year.

Some DPW respondents indicate that the migrant population has a lower protective services case load rate than other poor local groups and doesn't really justify this concentrated attention. The DPW offices indicated, however, that besides this project, there are no other DPW outreach or service operations to make their services more accessible by the migrant population than by other segments of the population.

In the south Texas communities where migrants winter, the problems due to migrancy may not stand out. In fact, there is known to be a certain respect for those who, despite their poverty, can plan sufficiently ahead as a family unit to be able to migrate. The amount of money families make in a relatively short time doing farmwork in the north far exceeds what those staying behind can usually hope for, although the costs of transportation and shelter, plus the need to live off their earnings for the next year, often reduce the financial advantages of migrating almost to zero. Social Services departments which could advise families in the decision of whether or not to migrate could be instrumental in helping a family become more financially stable in regions with better job prospects, but the migrant/nonmigrant distinction is not made and such assistance is not offered.

Migrant families who do not qualify for AFDC and are involved in child abuse and neglect cases requiring mandated foster care (AFDC clients' foster care is paid by the state), cannot turn to their county offices either. Generally, such offices, strapped for funds to serve full-year residents, identify migrating families as "transients." In fact, one DPW respondent noted that the money used to fund the TMC project, albeit federal and multistate, would have been more effectively applied to a serious need in providing foster care for non-AFDC recipients in the home base of the people it affected. On the other hand, a number of respondents in the private agencies surveyed indicated that the very stability of the migrant families permitting them to go on the stream each year produces a much lower need for such substitution services as foster care or adoption. Rather, it is the supportive services, such as health and day care, that are in critically short supply.

Due to the predominant Spanish speaking character of south Texas, it was common to find DPW employing Hispanics--not necessarily former migrants--on their services staffs. In Laredo, the DPW child welfare unit employs 25 nonmigrant Hispanics, including three supervisors, who work both as DPW caseworkers and in the Homemaker Service, which encompasses protective services functions of the agency. Other than employing Hispanics to facilitate services to the 80% Spanish speaking local population, or the small amount of time given to acquaint TMC staff with DPW procedures, none of the offices indicated that there had been any special work with their staffs to improve migrants' services through training workshops, studies, contracts, or hiring of staff to work specifically with the migrant population.

The presence of illegal aliens was cited as a problem by some respondents. An administrator indicated that the relatively few persons found during the application process not to have legal status would be reported to the Immigration and Naturalization Service. A respondent involved in protective services, however, indicated that there was indeed a considerable problem. A crisis situation involving child abuse or neglect sometimes requires stabilizing a family that included illegal aliens, in which case deportation might be involved, or reuniting a family with some members on either side of the border. It was indicated that the Border Patrol was helpful, but a formal understanding between the nations and the agencies involved is not in effect. The need was emphasized for an international conference on child abuse at which such issues could be addressed and a series of procedures developed.

Child Care

The primary groups involved in the provision of day care services to migrant children in the counties studied are as follows: the Associated City-County Economic Development Corporation (ACCEDC), the Texas Migrant Council (TMC), Colonias del Valle, Inc., and Organizaciones Unidas. In addition, several local school districts contract for preschool day care for the younger siblings of children enrolled in the Title I Migrant program. The DPW offices may purchase service slots through Title XX funds to provide day care for abused and neglected children, but the number of such placements involving migrants is not known, as DPW does not identify migrants within its caseload.

The term "day care" is used generically here, as providers work from a number of different funding sources. The programs run by ACCEDC, for example, the largest in the Valley, are funded primarily by Head Start. Head Start programs do not include infants, although TMC provides infant care through its mobile Head Start program. The TMC programs are supported mainly through Migrant Head Start. Colonias del Valle used Migrant Manpower and Title I Migrant Pre-Kindergarten funds for supporting its migrant day care program.

In this home base area, it is difficult to ascertain the number of migrant children served by these providers. With the exception of TMC, all day care providers serve migrants and nonmigrants. In the 1976 publication, Take Stock in Texas - Invest in Children, published by the state Department of Community Affairs, programs for children in Texas are presented in considerable detail but without an ethnic or migrant/nonmigrant breakdown. According to this source, in Cameron, Hidalgo, and Webb Counties combined, there were 53,115 children under six years of age, as determined by the 1970 census. However, the 85 day care centers or family day homes were able to care for only 3,299 children--slightly over six percent of the total under-six population. Only twelve were family day homes, and served about five children each. One-third of the day care centers were commercial facilities. Nonprofit day care centers, many of which care for children under government programs in accordance with income or other eligibility requirements, are the primary source of child care services for migrants in this area where 50,000 persons out of a population of 250,000 migrate each year.

These figures, particularly the twenty percent migration rate, point to the severe unmet need in the area. Assuming the typical migrant family size of five, with three children, an estimated 25,000 to 30,000 migrant children live in this area in the winter. Many are unable to obtain AFDC assistance due, for example, to the presence of a father who can work. The availability of work is very low as indicated by the large amount of food stamps usage in the Valley. In such homes, the mother may be free to care for her children, but the conditions of impoverishment alone are a valid reason for children to be enrolled in day care facilities. However, only 1,994 openings for children in nonprofit centers exist in these counties, which, even if they were all for migrant children, would only serve seven percent.

The largest provider of day care in south Texas is the Associated City-County Economic Development Corporation (ACCEDC), a Community Action Agency in Hidalgo County. Drawing on multiple funding sources, ACCEDC is involved directly or indirectly in many of the social programs for the population of the entire Valley. Their Head Start program consists of sixteen child development centers serving 990 children. Along with the other two CAPs in south Texas, they are grantees for the state's special program for children who are not receiving dental care from any other source. With complete health, nutritional, and curriculum-based programs, these centers constitute a major attack on the critical need for child care in south Texas.

Another provider, more specifically migrant oriented, is the Colonias del Valle organization, operating primarily in Hidalgo County, but also in Cameron and Willacy Counties. This agency receives its primary funding through the Department of Labor's (DOL) Migrant Manpower program, and, in association with that program, offers a small number of child care slots for families of its enrollees. In addition, it receives state funds to provide child care for four-year olds under the Texas Pre-Kindergarten Migrant program, one of two preschool programs the state operates under Title I Migrant. Finally, a small number of positions are held for placement of children referred by the Texas Migrant Council's Child Abuse and Neglect program. These slots are funded under Title XX, as TMC's program works in concert with the Department of Public Welfare. Colonias del Valle offers 150 child care positions, which, due to Title I Migrant funding, include an educationally oriented program with proper health and nutritional care. Colonias also provides services for their children under ACCEDC's special dental program, and is, along with a number of other agencies in south Texas, a grantee for the Food Stamps Outreach program funded by DPW under USDA's Food Stamps program. This program supports community workers who go to homes of families needing assistance or recently returned from their migrations, and helps them to complete the applications for food stamps. During the visit, referrals can be made for health care, Colonias' own manpower program, or social services through TMC, DPW, ACCEDC, and other providers.

The third primary child care provider in south Texas, the Texas Migrant Council, serves approximately 500 children through delegation to other agencies, such as Colonias del Valle, for care under Title XX. Also, about 250 children are served in eight centers run directly by TMC throughout the Valley. These centers are supported by both the Title I Migrant Pre-Kindergarten program and the TMC Mobile Migrant Head Start program which enables TMC to follow children and their families as they migrate northward each year. TMC is a grantee for the Migrant Manpower program, supporting about 30 child care enrollments. It also receives dental care for children through ACCEDC's special dental program, and, in connection with the Laredo-Webb County Health Department Migrant Health Clinic, provides nutritional assistance through the Women, Infants, and Children (WIC) nutritional program sponsored by USDA for mothers and children at nutritional risk.

One other provider of child care in the Valley, Organizaciones Unidas, serves relatively few children in Cameron County under the Title I Migrant Pre-Kindergarten program. Only 40 children are enrolled in its facilities, but full support services are provided through arrangements with Su Clinica Familiar, a migrant health clinic in Cameron County which also provides social services, and through use of the USDA summer feeding program.

Finally, two CAP agencies, operating at either end of the south Texas Valley, both offer Head Start programs. The Laredo-Webb County Community Action Agency operates its program through the Laredo Independent School District with summer and year-round Head Start programs, serving 800 children. This agency indicated, however, that few of those served are migrants. Often when the families return from their migration, all openings in the program's enrollments have been filled. In addition, families may not qualify for the program as it is intended for children of working parents, and migrants during the fall and winter months are often unemployed. The other CAP, the Cameron-Willacy Community Action Program, operates its own Head Start program, serving an estimated 300 children, about half of whom are migrants.

There are relatively few migrant-targeted child care programs in Texas, the largest home based area for migrants in the country. In fact, less than half of the two thousand slots in which migrant children could be enrolled actually serve them, although there is a migrant child population of well over 20,000. Many of these slots, are in programs that do not serve infants. The few in the Migrant Manpower programs and those slots supported under Title XX, serve fewer than 80 migrant infants. Many respondents evaluated infant care need as critical.

In the home base area, extended hours of day care operation are less important as parents are either unemployed or working at jobs more conventionally scheduled than farmwork. Typical operation time for these centers is 7:00 a.m. to 5:00 p.m. or 6:00 p.m. Due to the ethnic makeup of the area, most of the centers have staff with the same linguistic and cultural backgrounds as the children served; in many centers, the staff is one-third former migrants. Staff training on the special needs of migrant children has been given by some of the agencies, but because the staffs include former migrants, the child development training received is often sufficient.

Some of the formal linkages between agencies have been mentioned above--specifically, arrangements to assure proper health care and funding flows. Many other referral and organizational linkages exist among these agencies and others, as the need for services is great in south Texas. Those respondents indicating a need for greater coordination usually refer to linkages between the public agencies and the private or nonprofit organizations. Generally, although a family may not be able to obtain assistance at every agency, there is no lack of knowledge about where to go instead. This results in a flow of applicants from the public to the nonprofit groups, whose service, based only on migrant eligibility and an underlying sense of advocacy, is easier to obtain; this strains their resources while easing the caseload of public agencies obligated to provide services to all persons.

The perceptions among service providers in south Texas on the subject of target programs for migrants and their segregated facilities, cover a wide range. Many feel that there are now more services reaching migrants than reaching the nonmigrant rural poor in the area, due to past efforts of migrant advocacy groups resulting in special programs for migrants. Considerable resentment among nonmigrants has developed toward these programs. On the other hand, some say that it is important to distinguish between active and settled-out migrants so that only true migrants will receive additional help, as the settled-out families can obtain services more readily. Others feel that this distinction should not be made, as settled-out migrants still face many of the same economic problems faced by current migrants. These arguments persist in all topics covered by this report--social services, child care, education, and health care--as well as in areas indirectly related to child welfare, such as employment and housing.

Education

Fifteen of 24 school districts returning questionnaires operate Title I Migrant programs in the three-county area and serve 20,000 children. This represents almost 80% response; the LEAs not responding served slightly more than 6,000 children, according to a count during the 1975-1976 school year. Only two of the responding LEAs indicated that their programs included preschool child care, only about 150 migrant children five years or under. However, the Title I Migrant program gives funds to other agencies to provide this service, with almost 500 children enrolled.

For the LEAs responding, the average amount of funding received was $368,980, which reflects the large concentration of migrants in the area. These LEAs each had an average of 1,358 children in their Title I Migrant programs, an average of $269 per pupil expenditure in 1975-76. LEAs averaged 53 staff members (part and full time); only four had more than 60. The range in program size was great -- the smallest project received $25,100 and had six staff members; the largest, $1,123,475, had two hundred and twenty-one staff. All projects made considerable use of teacher's aides and other supportive staff to provide necessary intensive instruction and remedial assistance. In a typical project averaging 53 staff, only 15 were teachers. This home base area is where base line information on children in families planning to migrate is put into the Migrant Student Record Transfer System. Twelve of the 15 LEAs had at least one Title I Migrant staff member working as the MSRTS clerk, and the largest LEA had six.

All LEAs responding indicated health care was provided, although only ten reported immunizations. Nine of the fifteen provided breakfast programs; only a third provided accident insurance, and only two LEAs provided day care. Fewer than half had a social worker available, while slightly more indicated that psychological and career counseling was provided. Eight of the fifteen ran summer programs (migrants are seldom in the area in the summertime); seven indicated that their programs included outreach and recruitment to bring migrant children into programs. Nine of the larger LEAs included secondary level vocational courses. Twelve indicated that their programs were bilingual/bicultural in nature, and all but two indicated that their curricula included programs exclusively for migrants, ranging from special events including migrant parents, to an entire migrant school serving 688 migrant children in one of the large LEAs. Most other LEAs indicated that tutorial programs and intensive reading/math and language arts work were parts of their migrant programs. All participated in the MSRTS; two-third thought it was effective. Problems cited were pressure to complete forms, lateness of forms received, failure of in-stream schools to use the forms, inaccuracy, and duplication.

Three LEAs had schools which might have operated Title I Migrant programs, but did not. One LEA stated that a special program was unnecessary as the children had adequate achievement scores. Another indicated that the normal diagnostic and prescriptive processes the schools used were adequate to handle their needs. The third indicated that other state and federal programs, such as Title VII Bilingual Education and the regular Title I program, provided sufficient assistnace.

Finally, when asked what special needs of migrant children are not now satisfied, one-third responded none, and another half did not answer or cited needs of the school rather than the child (more funding, construction money, etc.). Those LEAs citing children's needs listed medical and clothing assistance, programs to permit retention of secondary credit, and counseling at the elementary level.

It is evident that migrant education programs in south Texas are very extensive, including several state and federal programs that complement the Title I Migrant program. The aggregate funding for the projects studied is in excess of $5.5 million, and, while this amounts to only $269 per pupil per year, the cumulative expenditure over time is considerable.

Health

As indicated above in this section on Child Care, there are several agencies to which migrants can turn for assistance in south Texas, but a pattern has developed that leads them more readily to grant-supported migrant agencies rather than to state-supported public agencies that often provide the same services. This is particularly true in health care.

In each of the three counties studied, there is a grantee for the federal Migrant Health Program. In Cameron County, it is separate from the county health department; in Webb County, it operates as part of the health department; and in Hidalgo County, it operates through a nonprofit organization working with the health department with support and coordination from other nonprofit groups.

The migrant health clinic in Cameron County, Su Clinica Familiar (Your Family Clinic), is separate from the county health department but part of the Cameron-Willacy Counties Family Health Services Plan, a nonprofit health services organization. Su Clinica Familiar exemplifies the tendency for services for migrants to be performed at migrant clinics only, although county health department clinics are also available to serve migrants.

Respondents at Su Clinica estimated a migrant population of 40,000 in their catchment area with more than 11,800 patient visits in 1976. Of 1,425 children treated by the pediatrician in 1976, 855 (60%) were from migrant families. However, only 31 migrant children received dental care. The respondent believed that an estimated 75% of the valley's migrants were being satisfactorily served by the clinic. The 32-member clinic staff includes two physicians, three nurse practitioners, two nurse-mid-wives, and a support staff (full- and part-time) of 25. Twenty-seven staff members are bilingual/bicultural. Twenty of the support staff are former migrants. The clinic receives its funding from fees, four federal health programs, and the local CAP which awarded a small grant to facilitate social services.

In Hidalgo county (population 200,000), the Hidalgo County Health Care Corporation (HCHCC) is the organization established by the county, to provide improved services to migrants. Thirty thousand persons are registered at the clinic, and there are an estimated 15,000 active users; a large majority of these are migrants. Forty percent of the users are under age 14; approximately 4,500 migrant children (3/4 of those served) receive services there. The nonmigrant portion of the clinic's case load is made up of seasonal farmworkers, as the clientele of the clinic is limited to the migrant and seasonal farmworker population by funding and organizational arrangements.

The estimate of this clinic's capability to meet community need is considerably lower than for the migrant health clinic in Cameron County. Here, only 25% of the migrants in the area are estimated to be able to obtain services. This may be due partly to the WIC and Maternal and Child Health programs available only through the county clinic which refers most migrants to the HCHCC clinic; and partly because **HCHCC** provides transportation only on a limited basis. The respondent cited a need for more dentists and other professionals on its medical staff. The respondent indicated that the depressed income of south Texas (which he reported to be $2,500 per capita per annum, the lowest in the nation) combined with program funding constraints prevent operations like this clinic from attracting and keeping physicians and other medical staff. To emphasize the disadvantages of migrants in targeted programs, the respondent indicated that the combination of these economic conditions and the accompanying high unemployment rate, plus the presence of a number of programs designed to serve only migrants constitute a strong incentive for migrants to continue to migrate each year. They can make a reasonable wage instream and still obtain needed services through migrant programs for the portion of the year they are in the home base.

The third migrant health clinic servicing the three-county area under study is run directly by a county health department. The Laredo-Webb County Health Department Migrant Health Project operates a clinic separate from the main department facility. Migrants who could be served by the county clinic are referred to the migrant clinic. Laredo is a less populated county with a lower proportion of migrants than Hidalgo and Cameron counties, but the patient load statistics provided by this clinic indicated that about as many migrant children were seen at Laredo-Webb as at the clinic in Hidalgo County.

Texas law prohibits payment of salaries to physicians. A frequent arrangement is for a physician to have his offices in a clinic but bill patients directly. The Laredo-Webb clinic, a smaller program than the other two discussed here, relies on local physicians, two of whom are pediatricians, to provide medical services at the clinic several hours each per week. This clinic directly employs only two nursing assistants, one L.V.N., and eight support staff. In the other migrant clinics in south Texas, almost all of the staff is bilingual/bicultural; here, however, only two clerks on the staff are former migrants.

It is primarily through their interagency arrangements, such as the special dental program administered by the CAP, that the Laredo clinic is able to serve a large number of persons. Also, as this clinic is part of the county health department, it provides (unlike the other two counties) the WIC program to migrants as well as to others. In addition, the Laredo-Webb County Migrant Health Clinic is an HEW grantee to study the feasibility of providing migrant health care in-stream through one common provider. The project, which uses Blue Cross coverage, permits additional outreach by the clinic so that local potential participants can be enrolled before migrating northward. This contact promotes improved health delivery at the same time. For example, while the number of children receiving pediatric attention in this clinic in 1976 was high, the number of migrant children receiving attention through home visits by clinic staff was a third higher--6,200. This program contributes to this clinic's ability to provide transportation when needed to and from the clinic, a service many migrant health clinics do not provide. Funds from the CAP and the local economic development programs also support the transportation services of the clinic.

The respondent at the Laredo-Webb clinic noted that migrants from the area have a very low settle-out rate due to few local opportunities for work. As many migrant families are ineligible for AFDC and its accompanying Medicare eligibility, but are able to receive services from the migrant clinic, there is a considerable incentive for them to remain migrants, living on their in-stream earnings during the off season, thus boosting the unemployment rate to 19%.

Farmworker Organizations

Colonias del Valle, Inc. (Hidalgo), Organizaciones Unidas, (Cameron), and the Texas Migrant Council (Webb), are three of the most active farmworker organizations in the Texas survey counties. Each organization operates manpower training under the Department of Labor Migrant Manpower program, and each provides comprehensive services and referrals to the migrant families who come to them for assistance. All are discussed above in this report as they provide substantial day care and social services to migrant children and their families.

Often, farmworker organizations are the primary advocates for low-income migrants and other farmworkers who live in their areas. Colonias del Valle received national attention recently when it was instrumental in obtaining modifications in a regionally-developed water systems plan that would have provided improved service to middle class homes and commercial areas but would have completely bypassed the impoverished communities along the Rio Grande. These colonias are the winter homes of many migrants, but they often have no water supplies. In a number of cases, water has had to be drawn from animals' watering-trenches on nearby farms.

Organizaciones Unidas provides services on a smaller, more local scale, and works closely with both the local migrant health clinic and Catholic Charities, Inc.

The Texas Migrant Council, a major Migrant Head Start program grantee, provides two programs that address one of the main obstacles to the migrant's ability to obtain services: mobility. These programs--a Head Start program and a Child Abuse and Neglect prevention program--involve work with migrant children and their families while in Texas in the winter, and then provide continuity of care by migrating with families traveling north during the summer. The Mobile Migrant Head Start program, knowing the destination of a group of families, drives ahead in vans, and secures facilities, prepares educational materials, and arranges for necessary services, so that when the families arrive, a full-scale, culturally-tailored child care program is available to serve the children as long as they are in the area. When they move, the program moves. The TMC Child Abuse and Neglect program, discussed in the Social Services section above, provides caseworkers who station themselves in northern areas where Texas-based migrant families are working, who have protective services needs. They are available to the protective services agency of the state should their assistance become necessary.

State Service Provider Agencies

Social Services

The state Department of Public Welfare (DPW), is the designated state agency in Texas for the administration of the Title XX program. Respondents in the Office of Coordination and in Protective Services were contacted. Although both offices indicated that no DPW operation identifies migrants within the client population served, both gave some evidence of DPW operations directed toward the migrant community. The Texas Migrant Council's Child Abuse and Neglect project was mentioned, as was the fact that the Department reviews and comments on proposed plans for Migrant Manpower programs at the request of the Governor's Office on Migrant Affairs (GOMA). These, however, were only illustrative and no details of operations or statewide overview were obtainable.

DPW has no funding for special migrant programs, despite an obligation to serve all persons. Comments were made which indicated that DPW knows that migrants are less able to benefit from their standard programs than are members of the general population. The point was made that because many migrant families cannot receive AFDC, as discussed above in this chapter, they are categorically eliminated from programs which use AFDC eligibility criteria. Offsetting this somewhat was the effort by DPW to increase availability of food stamps through its statewide Food Stamps Outreach program.

It was indicated that the department does in fact operate programs tailored to meet the needs of other special groups in the state (urban teenagers, military personnel, and timber products workers in east Texas), so its reticence to provide compensatory programs for the mobile but regular life patterns of migrants could be held up to scrutiny. Further, the need was cited for more bilingual staff, whose hiring might require waivers in the department's merit system. It was even suggested that DPW caseworkers should be provided regular counseling services to help them maintain an attitude which would not impede the intended purpose of their work, implying that a problem exists.

Another comment concerning the contradistinction between the department policy of "equality of service" and known special needs was made by a Protective Services administrator who noted that because substitute care is so difficult to provide for migrants, it is likely that very little is provided. He also noted that the proportion of cases involving substitute care (usually about ten percent of a caseload) was much smaller for migrants than for the rest of the service population. The respondent held that migrant adults are unlikely to qualify as adoptive parents because they do not remain in the home base area long enough to complete formal placement processes and they are seen as having "unstable" homes. This seems to be a characterization of convenience, equating the migrant mobile lifestyle with a lack of family stability. While clearly outside the traditional concept of adoptive homes, migrant families are held by many to be more stable than other rural poor.

Finally, it was reiterated at the state level that many counties refuse to pay the cost of mandated foster care for non-AFDC families if they do not consider a family to be permanent residents. Migrants' transience was cited along with poverty and extreme dependence on employers as three clearly identifiable characteristics that set migrants apart from others. The need for targeted education programs for migrants was emphasized, but there was no perceived need for special child welfare services or interagency coordination for migrants by the Department of Public Welfare.

Child Care

There is no state level office that is solely concerned with the operation of all child care programs in Texas. The DPW Title XX program includes child care as a social service which can be offered to its clients, but AFDC eligibility or protective services case designation, both of which seldom include migrants, are often prerequisites. The only known statewide child care programs that do benefit migrants directly are those operated by the Texas Education Agency as part of the Title I Migrant Education program, discussed below in the section on Education.

Migrant child care throughout the state is similar to the arrangements in the south Texas area in that a number of sources contribute, but no one private or public coordinating body ensures that the need is met. Funds from Migrant manpower, Head Start, Title XX, and Title I programs are all used to address this need, but always as an adjunct to other purposes. In a number of areas outside the lower Rio Grande valley advocacy farmworker organizations are the primary providers of this service.

Education

The Title I Migrant Education program in Texas, the Texas Child Migrant Program, served 65,395 children in 1975-76 at a cost approaching 19 million dollars. Over 120 LEAs made use of the funds; few, however, used it for secondary-level programs. The state office (respondent) indicated that information was unavailable on the number of LEAs enrolling a sufficient number of migrant students to qualify for the program but which chose not to apply for Title I Migrant funds. The number of migrant children unserved was estimated to be 40,000--almost two-thirds the number who are currently receiving services, a serious underutilization of the present program.

Although this problem was acknowledged, the state respondent indicated that efforts to influence LEAs to participate in the program should continue through the regional LEA offices which know their locales better than the state office. He estimated that perhaps only one-half the children eligible to participate in the program were enrolled.

Although Title I law permits the SEA to award funds to an agency other than an LEA to operate the Title I Migrant Education program in a locality, only three instances were identified, all concerning preschool services. It is not known why alternative sponsors have not been selected to provide services to the 40,000 eligible children not currently participating in the program.

The state LEA office indicated that few LEAs operate summer programs due to shortages of funds and fewer migrants. Summer programs are usually on only half-day schedules, and therefore do not match parents' working hours. Both summer and regular school year programs provide supplementary services such as health screening and nutritional help in addition to the compensatory educational components in reading and language skills. Although not all of the LEAs provide children with breakfast programs, most LEAs do. In the preschool program, breakfast services and additional support, such as clothing, were provided making this program, with its core preschool educational component, more comprehensive than other preschool programs.

There is considerable targeting of the states' program at the early elementary and preschool levels. Forty percent of the children served are between the ages of four and eight. In the south Texas area, the Title I Migrant Pre-Kindergarten program provides almost half the child care slots in which migrant children are enrolled. However, it takes emphasis away from other program objectives. A secondary level program, as indicated at the beginning of this section, is sorely needed in order to reach a greater number of students ready to choose a vocation. Decisions not to go with migrant farmwork might be made if sufficient counseling, information, and training in alternative jobs were available. There are too few vocational training programs because expenditures are far more costly per vocational student than for elementary pupils.

At the state level, four of the six staff consultants in the Title I Migrant program office are former migrants. One of the current unmet needs is the transfer of educational records for migrant children. The MSRTS system was cited as being a useful tool for conveying health information, but was designed in such a way that the education information was not useful, or, in fact, often used by receiving schools. The main reason given was differences in curriculum planning among teachers. An additional problem is the home base enrollment of migrant children onto the MSRTS which constitutes a considerable strain on the resources of many Texas schools.

In Texas, where many of the schools serving migrant children do not want extra federal funds to serve migrant children more effectively, these children are assumed to be just another segment of the student population. While this is desirable insofar as it does not segregate the migrant child from his nonmigrant peers--a potentially stigmatizing situation--it does mean that the migrant child may often receive an education no different from other children despite an early life considerably more disruptive than other children's. Considering that until 1969 no child was permitted to speak any language other than English in Texas schools, and, despite the influx of federal and state funds for migrant and bilingual programs, the education that migrant children actually receive may not adequately address their special problems.

Health

The state Department of Health Resources, and the Department of Public Welfare, indicated that migrants are not identified as a separate group, under the rationale that they are eligible for all of the Department's services. However, the health department respondent acknowledged that while "migrant children in general have the same health problems as others in their socio-economic group...due to high mobility of the migrant, health problems are compounded." Nevertheless, it was indicated that no special provisions are made for this group.

DHR has no staff or budget allocated specifically to serve migrants, has done no training or entered into contracts for service for this group, and, if there are any former migrants on its staff, their number is unknown, i.e., their background and experience are not being used by DHR to serve migrants more effectively.

Prior to the federal migrant health program's decision to shift from supporting state health departments in establishing and developing migrant health programs to the direct federal funding of migrant health clinics, DHR was directly involved in migrant health services. Now, although DHR continues assistance and consultation to these clinics, there is no formal link. The inability of the Department to incorporate migrant consumer input into its migrant health program planning process at the state or local levels was given as a contributing factor to the state's losing the program. The only migrant-related activity of the department is placed within the Sanitation Division, where there is a staff responsible for migrant labor camp inspection. This was the unit assigned to respond to the present study.

There are DHR programs which benefit migrants in general and migrant children in particular, although the number receiving the services versus the number needing them is unknown. EPSDT and the state immunization program, required for school admission, were felt to have high impact although EPSDT requires AFDC eligibility which few migrant families can obtain. The WIC program, unlike the others, is not administered through the local health departments exclusively but can be contracted to other organizations, as has happened with several migrant clinics in the state. The section above on health gives an index of numbers served versus need. It is clear that there is a need for special health programming for migrants, but the state level is not where it is coordinated or supported, although Texas is the home residence of many migrants. Hospitalization was, for example, cited as a critical need, as the migrant clinics receive only token funds, and other sources are unavailable; the AFDC eligibility requirement bars many migrants from obtaining Medicaid. The Department has had the experience to discover these problems, yet operates no programs to address them. There may have been no substantial effort to do so from within the department: a respondent indicated that education and language prevent migrants from being willing to participate in policy-making. The statement may have indicated inadequate effort on the part of the state in seeking migrant input. The response concerning recommendations for improved services to migrants also underscores the Department's desire not to address the special health needs of migrants directly. It was indicated that the only way to serve them is through the creation of a single agency to provide all migrant services, including health, with which other "general population" service agencies would be forced to cooperate, rather than through an approach relying on coordination among existing agencies.

Additional Services

In Texas, there are at least three agencies operating at the state level to improve services to migrants, even though there are few units in most state agencies assigned to migrant affairs. The Governor's Office of Migrant Affairs (GOMA), the Good Neighbor Commission (GNC), and an Interagency Task Force on Farmworkers may seem to overlap, but their functions are fairly well defined and complementary. The Governor's Office is primarily concerned with state policies impacting on migrants. This office also operates a program that serves some migrants directly under the DOL Manpower program (CETA). While sections of the Act are designed to be run be state Governor's offices (the Governor has discretionary powers to allocate monies based on job training needs within the state), the Migrant Manpower program of CETA is usually not under state sponsorship but is administered directly through nonprofit farmworker organization, one or two of which may run the program for the entire state. In Texas, through an arrangement with DOL, three such grantees are used. Some of the Governor's discretionary funds are allocated to the migrant population through an internal set-aside to GOMA, due to the very large number of migrants and the high unemployment rate in Texas. The office operates a portion of the state migrant manpower program, and is in a position to oversee the entire program.

The Good Neighbor Commission (GNC), on the other hand, does not operate programs directly but is charged with maintaining information on migrants and state services available to them. Each year, through its Interagency Task Force, GNC assesses the status of migrant programs in the state, compiles aggregate service and demographic statistics, and prepares an annual report presenting information on education, housing, health, and employment, with recommendations to the Governor for improved services and coordination. The 1976 report scheduled for mid-1977 publication, is more policy-oriented than reports for previous years, and structured closely around programmatic recommendations. The Interagency Task Force used by the Good Neighbor Commission in its data collection and assessment activities is comprised of representatives of the Title I Migrant Education program, the DPW/TMC Child Abuse and Neglect project, the Department of Health Resources, the state Rehabilitation Commission, the Bureau of Labor and Standards of the state Employment Commission, and the state Highway Department.

GNC works with the agencies providing data to improve services for migrants while addressing the difficult issues of segregation, discrimination against nonmigrants, and use of existing institutions. For example, work with the food stamps office in DPW has resulted in a policy identifying migrants within the food stamps client population, so that their migrating patterns and seasonal needs can be identified in the future. DPW already operates the Food Stamps Outreach program, of benefit to many migrants. GNC efforts also include working with public and private service agencies at local levels to improve their outreach to migrants.

GNC advocates a multiservice agency approach so that factors of the migrant lifestyle which creates special needs can be best addressed. These centers could be equipped to provide a number of services, for example, health care, food stamps, child care, and referral services. This approach is found in some states in the north, where migrants arriving to work the crops often need many things at once. Such a program could be independent from, but supported by, existing service institutions, and could serve nonmigrants as well, thus minimizing the segregated, stigmatized association that many migrants and nonmigrants alike now feel for migrant programs. Whether such an approach is politically and administratively feasible is dependent on other factors, but GNC's ongoing efforts may point the way for improved services for migrants in Texas and throughout the three migrant streams in the United States.

CHAPTER XII

WASHINGTON: YAKIMA COUNTY

Washington state is a major migrant farmwork state. It is important both as an in-stream work site, due to its large amount of agricultural crops and products which need hand tending and picking, and, increasingly as a home base state, the variety of farmwork can provide an income to an intrastate migrant family for ten or more months of the year. Major crops in Washington include apples, grapes, hops, asparagus, and a variety of fruits, such as melons and berries.

Yakima County, in the south central portion of the state, includes about four-fifths of the Yakima Valley, the largest single intensive agricultural area in the state. As this part of the state is in a desert, the area is completely dependent on extensive irrigation systems. With the water brought in, the area has become a prime growing area for apples and fruit crops. In recent years, greater and greater amounts of wine grapes and hops have been cultivated. Much of the valley is on the land of the Yakima Indian Reservation, but this does not affect local agriculture. Generally, the separate tribal government and courts only extend their influence over those parts of the reservation that are not in the heavily populated areas of the valley.

There are approximately 15,000 migrants in Yakima County during the farmwork season. These farmworkers share equally with the growers in a dependence on water to feed the irrigation systems in the valley. The future of Yakima Valley as an area of intensive agriculture has been rendered uncertain by severe drought conditions in the west and northwest. Many migrants were put out of work in 1977, and continued drought could have disastrous consequences for the 15,000 migrants in Yakima County.

Services and Needs in Yakima County

Many different service agencies and programs operate in Yakima County and provide services to migrants. The county houses the statewide headquarters of the major farmwork organization in the state, Northwest Rural Opportunities, Inc. (NRO), which is funded by the state and the U. S. Departments of Labor, Agriculture, and Health, Education, and Welfare. The state migrant education program has its Identification and Referral Project, and its planning offices, located in the county. Additional service programs in Yakima County include a migrant health clinic, a United Farmworkers information and referral center, three offices of the state Department of Social and Health Services (DSHS), three day care centers run by NRO, two summer migrant day care centers run by a local school district, and United Community Action (UCA), a Community Action agency which supports a community center recreation program for migrant youth in one of the smaller towns. In addition, the county health department operated the only migrant camp or organized migrant housing facility of any kind in the county, a "camp" consisting of 19 parking spaces and communal sanitary facilities. Since migrant housing came under federal inspection several years ago and most growers in the area closed their camps rather than bring them up to standards, almost all migrants in the northern half of the county make encampments along the banks of the Yakima River. One of the local welfare offices supports a volunteer program which provides outreach and referral services to these families.

Social Services

As indicated above, there are three local offices of the state Department of Social and Health Services in Yakima County. Information was obtained from all three offices. There is no one central office for the county, and the three offices appeared to operate with a fairly high degree of autonomy. As a result, the information obtained does represent program operations throughout the county, but does not necessarily do so in a coordinated manner. There is a regional DSHS office in the county, but its jurisdiction covers areas outside of the county and its functions are purely administrative.

None of the offices keeps records of the number of migrants served within their client population. One respondent said, "We serve anyone who walks in that door." As a result, it was necessary to ask respondents if they could estimate the number of migrants served by service category. None could provide estimates, but respondents at two of the offices were willing to indicate those categories in which they were relatively certain that no migrants had been served in recent years. These data are presented in the table on the following page.

By scanning down the "migrant" columns it can be seen that for two of the offices there are only three instances of services provided for which the respondents were sure that they were in fact serving migrants. It can also be seen that valuable services, such as EPSDT, foster family care, and day care, are in some cases provided to nonmigrants but not to migrants. The special circumstances of the migrant family may explain why some services are difficult to provide, but does not lessen, and in fact usually increases, their need for these services, to which they are entitled under Title XX law.

An important service provided by two of the DSHS offices is outreach, which increases migrants' accessibility to services. Outreach workers are primarily volunteers from the community who go to migrant camp areas and

TABLE 2

Populations Served by Local Yakima County Welfare Offices

Service	First Office General*	Second Office General	 Migrant	Third Office General	 Migrant
Adoption	yes	yes	?	yes	?
Day Care	yes	yes	0	yes	?
Day Treatment	0	0	0	0	0
Foster Day Care	0	0	0	0	0
Foster Family Care	yes	yes	0	yes	?
Group Home Services	0	yes	0	yes	0
Homemaker Services	yes	yes	0	yes	?
Institutional Care	0	0	0	yes	0
Residential Treatment	0	0	0	0	0
Maternity Home	0	yes	?	yes	0
Protective Services	yes	yes	yes	yes	?
Shelter Care	yes	yes	?	yes	yes
In-home Social Services	yes	yes	?	yes	0
Services to Unmarr. Parents	yes	yes	?	yes	yes
Chore Services	yes	yes	0	yes	0
Family Planning	yes	yes	?	yes	?
EPSDT	yes	yes	0	yes	?

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*Did not indicate breakdown

Yes = Service is provided to this group.
0 = Service is not provided to this group.
? = Not known whether service is provided to this group.

counsel newly arrived migrants and other families as to services available and application procedures. They also provide referrals to a variety of service providers. The outreach workers are permitted by the local DSHS office to assist the migrant family in preparing an application for assistance, and can perform some of the preliminary verification work, but an adult family member must come in person for a review of the application by an eligibility worker before assistance can be provided. Even with the assistance provided by outreach workers, a waiting period of a week is not unusual for obtaining services, even emergency food assistance. The application for assistance in Washington state, appended to Chapter I of Part Two of this report, is a formidable obstacle to obtaining needed help for a family with little or no food or money. It is a nineteen-page document filled with detailed questions about many aspects of a family's situation that would seem to have little bearing on proving the severity of their immediate need, yet this form must be completed even for emergency food. The larger of these programs also has at its disposal a certain amount of emergency supplies, including food, gasoline, cooking utensils, blankets, and clothing.

The salaried head of the volunteer program, a caseworker who is bilingual and a former migrant, is the only staff member assigned specifically to work with migrants. There are no funds targeted especially for migrants. Two of the offices indicated that there are a number of bilingual persons on their staffs.

Respondents at each DSHS office indicated a knowledge of other service agency programs, and reported that interagency coordination and mutual referrals are a part of operations. As indicated above, the DSHS offices do not coordinate closely among themselves. The acting director at one of the offices was not even aware of the migrant volunteer program being operated by one of the others, for example. All three offices, however, make use of other agencies in their intake processes, and DSHS is considerably more liberal than local welfare offices in other states covered in this study in terms of its willingness to permit other agencies to assist in the actual preparation and verification of assistance application forms.

In sum, social service delivery to migrants is inadequate despite valuable efforts in providing outreach. Several agency respondents indicated their recognition of the institutionalization of the gap in services between those provided to the nonmigrant population and those provided to migrants. They explained that the reasons migrants were not served was that many of the DSHS services were "inappropriate" to migrants' situation.

Child Care

The two providers of day care for migrant children in the county are Northwest Rural Opportunities (NRO), the farmworker organization, and the Yakima school district. NRO day care services are more extensive. In Yakima County, NRO operates five centers each serving an average of 50 children, and about 65 children during the peak season. The Yakima School district operates two summer day care centers in facilities used during the rest of the year by the local Head Start programs.

One NRO center and one of the school district centers were visited. Both day care centers serve infants and toddlers as well as preschool-aged children. Slightly more than one-third of the enrollment at each center was comprised of infants and toddlers. The NRO center serves children up to six years of age while the school district center includes children up to twelve years. The hours of operation at both facilities are from 5:00 a.m. to 6:00 p.m., and these hours match the working hours of migrant parents. The educational curriculum for infants and toddlers includes infant and child development and language development. School-aged children at the school district center study reading and mathematics, and receive Red Cross swimming instruction. The NRO center provides children aged three to six with language instruction, music and fingerplays, and biannual developmental screenings. All instruction at the NRO center is bilingual. The school district center provides transportation for the children, many of whom must leave home as early as 4:30 a.m. to reach the center by 6:00 a.m. The NRO center does not provide transportation. The school district center staff includes a full-time nurse, and the NRO staff has a part-time Licensed Practical Nurse.

The school district center staff of twenty-seven includes nine bilingual present or former migrants, five of whom are teachers. The NRO center employs a total of eighteen persons, thirteen of whom are former migrants, including one teacher, nine teacher's aides, and one outreach worker. All center staff were bilingual. Both centers used full-time outreach workers to maintain liaison with the families and assist with problems. There are active Parent Advisory Councils affiliated with both centers.

Coordination between the NRO center and other agencies appeared to be strong. This is probably due to the center's association with NRO, which supports many community activities. The school district center represents successful program coordination insofar as it is funded jointly by the Title I Migrant Education program and the Title XX Social Services program under contract to the school district. This center, however, clearly had fewer working connections with other organizations than the NRO center. The school district center director, for example, indicated that his program had little contact with the county health department, and none at all with NRO or the local Community Action Program, both of which provide children and youth services for migrants in the Yakima Valley.

Both centers had, of course, encountered problems in the operation of day care programs, and the center directors indicated that these difficulties should be addressed at the policy level. Licensing was perhaps foremost among these, partly because there is such a great need in the state for short-term day care centers, which are the hardest type to license. NRO staff noted that no additional state funds are made available for the costly procedure of bringing day care centers up to licensing standards, nor is the reimbursement rate raised to cover such expenses.

Another problem was that the DSHS Title XX payment schedule for migrant day care is the same as for nonmigrant, and the rate for infants is the same as for older children. Migrant day care is more expensive than nonmigrant day care because the hours of operation are longer; infant care requires higher staff/child ratios and special equipment. The rates payable to the facility once a child is determined to be eligible are still, according to NRO, below the costs of providing day care services. Currently, the DSHS reimburses $6.09 per day while average costs are $8.09 per day.

Additional problems were identified by the center directors. The NRO center is housed in three trailers which are in poor condition and cannot be replaced due to lack of funding. Because the school district day care service is seasonal, it suffers from the problems common to short-term programs. The administrative tasks of staffing and equipping the center and of finding subsequent employment for center staff leave the director little time to supervise the program.

Day care services in Yakima County are hindered by the difficulty of providing sufficient short-term migrant day care programs due to present difficulties with the various programs that can be used to fund such operations. Local welfare offices have the ability to provide day care through Title XX for families that meet AFDC requirements, but there was no information indicating that migrants are served in this way.

Education

Information was obtained from four of the nine Local Education Agencies (LEAs) operating Title I Migrant Education programs in Yakima County. The largest of these four programs served 1,153 students; one program had 72 children enrolled. Per pupil expenditure averaged $216, but ranged from $417 at the smallest program to $155 at the largest. Each LEA surveyed included several schools operating migrant programs. The average period of time during which migrants were enrolled each year in these LEAs was just less than nine months.

The programs offered in these schools centered around either the remedial approach, largely through the use of teacher's aides for individual attention, or the use of resource rooms to increase the amount of material and flexibility available to the child in improving achievement scores. Summer migrant programs are operated at all four LEAs surveyed. Another LEA in the county, which enrolls about 1,200 migrants, does not operate a summer program. Secondary school students may receive both career counseling and vocational training. All four LEAs had bilingual/bicultural instruction, although the number of children served was hard to determine. One LEA reported that 100% of its migrant students receive bilingual/bicultural instruction while reportedly only 20% participated in such programs at another LEA. Three of the LEAs showed intensive attention to students' needs in their staff/student ratios, which were 1:33, 1:20, and 1:38. The fourth LEA, which had the largest program and the lowest per pupil cost, showed a ratio of 1:82.

Supportive services at all LEAs were comprehensive, although the extent to which they were provided to migrant children varied greatly. All LEAs utilize the Migrant Student Record Transfer System. All four LEAs reported that health diagnosis and treatment were provided; depending on the LEA, from 10% to 100% of the students were covered. Only one LEA indicated that immunizations were provided. None of the LEAs operated a breakfast program, and only one indicated that preschool day care was provided through the school. Psychological counseling and a social worker were available at all LEAs, and served from 30% to 100% of the students, "based on need." Outreach and recruitment services also differed. One LEA that serves 650 migrant children indicated that it does not provide outreach or recruitment. Another reported that this service covered only 20% of its migrant children.

The MSRTS was viewed negatively by school officials at the four LEAs surveyed because insufficient information is entered by other schools in which the migrant students have been enrolled. An official at one LEA indicated that the system was "a waste of time, money and effort." A large number of discrepancies are found in the system: for example, records known to have been entered are lost. The health portion of the records was judged as "fair" in quality.

Coordination between the schools and other service agencies consists largely of linkages for health and social services. The migrant health clinic operates an unusual state funded preventive dental outreach program in the schools. In the southern part of the county, the schools provide direct referrals to social services because the state Title I Migrant Program Identification and Referral Project based there has outreach workers who perform this function. The county health department conducts some screening at schools without this service. The local Community Action Agency works with the schools to encourage their use of the USDA school breakfast program.

The fact that only one of the four programs has a nurse on the staff indicates the need for good coordination between the LEA programs and available medical care. Health services could be coordinated through the school health units, which may or may not be able to handle the health care needs of migrant children, or through local facilities, such as those discussed below.

In conclusion, it seems that there is an effective, functioning network of compensatory education programs for migrant children in the Yakima Valley. According to state sources, these four LEAs, plus the other five from which responses were not received, served a total of 4,461 migrant children in 1976. It is clear that the Yakima Valley has the largest single migrant education program in the state.

Health

The Farmworker Family Health Center and the county health department are the two primary sources of health care for migrant families in Yakima County. The extensive outreach services of the Farmworker Family Health Center, a migrant health clinic, combined with its arrangements with farmworker organizations and school migrant programs, indicated that most of the health services provided to migrants are performed by the migrant health clinic.

Unlike many other clinics funded by the Migrant Health Act, the migrant health clinic caters almost exclusively to migrants and is not the main local health facility. The clinic serves migrants in most of the Yakima Valley area, although migrants in some outlying areas are served less well than those more centrally located. The clinic operates a mobile clinic that travels throughout the valley providing screenings and referrals. When screenings reveal a need for treatment, the necesary care is paid for by the clinic if the family is unable to pay. It is estimated that expenditures to cover health treatment cost the clinic $200,000 per year. The clinic provides WIC nutritional support services, and has approximately 500 WIC slots used for temporary enrollment of migrant children suffering from nutritional deficiencies. Until recently, the clinic also had a fleet of radio-equipped cars to provide transportation for clients. It was estimated that the migrant clinic meets only 10% of the farmworker health needs in the valley, and that only about 40% of the need is met by all sources of medical care combined.

The clinic is staffed by two physicians, two medics, two nurse practitioners, a dental team, and six outreach workers. The dental program, a unique state-funded service, provides free preventive and remedial dental care to all migrant children up to age 12. Most of the staff is bilingual; many are former migrants. The clinic has working relationships with NRO, the county health department, local schools, and a ministerial association that provides emergency aid. Funding sources for the clinic include: Title XX, Family Planning, WIC, Maternal and Child Health, and the Migrant Health Program.

Clinic staff members identified a number of problems in service delivery, most of which center around difficulties in establishing eligibility and and processing clients. In order for migrant children to receive medicaid EPSDT services, they first must establish eligibility for welfare. Clinic personnel hold the opinion that the welfare department is overly rigorous in enforcing regulations for awarding aid. In fact, some migrants have sought legal assistance to ensure that their applications are processed fairly. In several cases, DSHS employees have reviewed the past assistance records of applicants. This review may uncover errors in past assistance awarded. If it is found that the family was overpaid previously, an attempt is made to collect the overpayment from the family, even if it was due to the eligibility worker's error. Deductions from the amount of aid to be awarded at the time of application are one means used for collecting on previous overpayments. These procedures render the applicant's right to assistance arbitrary, and cause great reductions in the numbers of eligible persons, including migrants, who apply for aid. The problem of transportation hinders migrants' access to health care in Yakima County as it does elsewhere.

The Yakima County Health Department serves migrants directly through only one program; the health department operates the local migrant "camp" which consists of 19 automobile parking places and shared sanitary facilities. Migrants receive treatment for venereal disease to the extent that state and local staff are working on the problem. Screening for typhoid and shagella is the only form of outreach provided that may involve migrants as those diseases are controlled by the department due to their effect on community health. Some outreach services are provided, but since the health department does not provide transportation, outreach services to migrants are limited.

There are four former migrants on the health department staff, and two of these are field workers. The health department is currently engaged in a major effort to reorganize operations. Needs assessment will become an integral part of department operations through the reorganization, and represent the first step toward determining that the needs of migrants are defined so that they may be addressed.

There are several problems involved in health service delivery in Yakima County. The transience of migrants presents an obstacle to the provision of services because, often, migrants are not in the county long enough to be diagnosed or treated. The fact that many migrants do not carry health records with them while in-stream complicates rapid, accurate treatment. Transience also interferes with continuity of health care and follow-up services. Referrals are problematical for the county health department because there is insufficient reporting on treatment and follow-up. This affects migrants as the migrant health clinic receives many migrant clients on referral from the county health department. Outreach activities are limited and transportation is unavailable, and these services would increase migrants' access to health care.

Even though there are two health care providers serving Yakima County, the needs of migrants are not met. Both the migrant clinic and the county health department administer WIC and Medicaid EPSDT services, and even these programs do not reach all of those eligible. For example, in 1976, the county health department estimated that 15,000 children of the general population were eligible for EPSDT screening. A total of 2,200 screenings were conducted by the two providers. Despite coordination between health care agencies in the county, many persons in need of care do not obtain medical attention or treatment.

Additional Services

United Community Action (UCA), the community action agency in Yakima, operates several programs throughout the county: a community center for youths in one of the smaller town; the federal weatherization program for improving home insulation; and support for a small agricultural cooperative. The agency is under the direction of the county board of supervisors. The community center draws between 30% and 40% of its clientele from the migrant population, and provides some tutoring. The center functions as a place away from home where youths can go for recreation, but it offers few activities. However, this is the only one of the three currently operating programs that directly serves migrants.

UCA has other community involvement activities underway. Although these activities are not yet funded, they are more capable of benefitting migrants specifically. UCA staff are actively working to encourage county schools to utilize the USDA School breakfast program. This would certainly improve the nutritional status of migrant children who attend the schools. UCA has been working to have the Title I Migrant office reserve a portion of funds available for a mobile classroom to bring the Title I Migrant program to migrant camps furthest removed from Yakima County schools. Also, UCA is striving to encourage growers to permit farmworkers to reenter the fields after harvesting and take for their families whatever usable fruits or vegetables remain. To minimize pilferage, such 'gleaning' is not now permitted. The otherwise useful unharvested food that remains after machine or hand harvesting is customarily left to rot or be burned off when the field is prepared for the next crop.

The small size of UCA and its status as an arm of the local government effectively deter it from working more closely with advocacy agencies and from serving migrants more directly. Were interagency politics not a problem, this agency could, for example, be an effective neutral sponsor and/or coordinator of countywide outreach efforts to the migrant community by all agencies serving migrants.

Farmworker Organization

Northwest Rural Opportunities, Inc. (NRO), discussed above in the section on Child Care, is the major provider of migrant day care for both Yakima County and all of Washington state. The degree to which NRO is established in the communities it serves, the various migrant programs it operates, and the strong advocacy role are the basis for NRO being the primary representative of farmworkers in Washington. NRO operates a network of migrant day care centers statewide with funding from a variety of sources, including Title XX monies. At present, the primary rationale of the state in providing Title XX funds to support the NRO migrant day care program is that, if this money were not made available, the program would cease to exist. As the state continues its support on an ad hoc basis subject to budgetary shifts each year, NRO constantly faces the possibility of imminent termination of the program. Planning for the future, with the cost savings that good planning could bring, is thus impossible. Also, the support from the state helps only with basic costs. If it were not for the other sources of support, the program could not maintain the high level of educational development content that it now has.

In their role as farmworker advocates, NRO personnel are acutely aware of the many differing definitions and eligibility requirements involved in the various programs it administers. A standard federal definition of the term "migrant" and the automatic granting of eligibility to persons meeting this definition for federally funded social and medical services assistance would save massive amounts of funds now spent determining eligibility for migrants who clearly are in need of such assistance. In addition, the regulations of many federally funded service programs specifically prohibit the use of funds for inter-program support that a consolidated provider like NRO depends on to maximize services. Difference in federal program requirements for reporting and accounting alone generate a paperwork burden that can seriously impede the ability of a farmworker organization to provide the services for which funding has been granted.

State Service Provider Agencies

Social Services

The Department of Social and Health Services is the designated Title XX administering agency in Washington state. This agency contains the social services, health, and benefit payments units of the state government. Funding support for migrant day care is the only direct social service provided to migrants by the DSHS. Health services are discussed below under Health. The number of migrants served by DSHS social service programs other than day care is now known as agency records do not identify any clients as migrants.

DSHS provides 650 year-round day care slots and 750 short-term slots for migrant children through state Title XX funding allocations totalling approximately $900,000. Almost $700,000 of these funds are allocated to NRO migrant day care centers through local DSHS offices. The NRO day care program receives half of its budget from the DSHS and half from four other funding sources. The director of the NRO day care program openly acknowledges that, without the state funds, the day care program could not exist. The DSHS monitors enrollments on a monthly basis and only pays for those slots that were occupied for a whole month. This represents a compromise between the need of day care providers to hold slots open for the arrival of unexpected migrants and the need of the state to maximize cost-effectiveness.

DSHS funding for migrant day care is coordinated at the state level but not as a separate, identifiable migrant day care program. An assistant to the director of the DSHS Office of Family, Adult and Children's Services handles the unique needs of the migrant centers as part of her work. Between 1974 and 1975, DSHS staff included a State Migrant Day

Care Coordinator. The work of this coordinator was invaluable in demonstrating the need for migrant day care through preparation of a needs assessment and through the technical assistance provided to community groups that wished to establish and operate short-term migrant day care centers. Funding for this coordinator's position has been discontinued.

Other than day care, DSHS provides no social services targeted to the migrant population in Washington. The Protective Services program manager stated that there is no protective services worker specifically assigned to work with migrants, nor is any portion of the protective services budget targeted to serve migrants. However, it is likely that migrants receive protective services as part of the general population. There are no funds available for additional outreach to improve child protective services to the migrant population.

Child Care

The major provider of day care to migrant children in Washington is the farmworker organization, NRO, which serves at least 650 children year-round plus 750 children on a short-term basis. Title I Migrant Education also offers preschool care to more than 400 migrant children through a contract with the farmworker organization. There are no Migrant Head Start programs in the state, so day care is not provided through Migrant Head Start, as is commonly the case elsewhere.

DSHS funds migrant day care through an informal allocation of a portion of its Title XX funds to existing migrant day care centers, most of which are run by NRO. Migrant day care is not a line item in the State Title XX plan, and migrants are eligible for participation in the migrant day care centers only if they meet Title XX eligibility requirements which are based on provision of a particular service only to those whose incomes are below a certain level, usually a percentage of the median income level in the state. For child welfare services, this requirement is 35% of the median income. In addition, both parents must be working and/or in training programs. The difficulty of completing the Title XX application form becomes an obstacle to eligibility itself. Washington's 19-page application form is appended to Chapter I of Part Two of this report and speaks for itself. NRO also uses a criterion concerning the percentage of earnings derived from agriculture in determining eligibility for the migrant programs.

At present, DSHS uses two obscure but significant procedural arrangements to fund migrant day care programs specifically and effectively, without having an explicit program for the purpose. The first of these is the ongoing support for NRO and whatever other community based, short-term migrant day care programs may be organized around the state. The second is a waiver for migrants of the maximum amount per family that can be spent by the state on day care. For the general population, there is a limit of $304 per year; for migrants, presumably meaning only those in NRO centers where a test of migrant status is made, there is no such limit.

If DSHS were to support the adoption of group eligibility for migrants, then the number of migrants who could place their children in non-NRO day care centers might increase due to the ease of registering for assistance at the local DSHS offices; theoretically other programs would become more available to them as well. However, to support group eligibility would require a greater commitment to migrant programs by DSHS. Thus, the pressure can only increase on the department in coming months either to substantially improve its services to migrants through group eligibility, or to discontinue even its current, almost informal arrangement for assisting them. While the decision to adopt group eligibility by a state requires substantial support from the population in question, it is clear that there is a situation in Washington that requires the department itself to own up to its own advocacy in the past and support adoption of group eligibility. The difficulty in doing so, unfortunately, is that due to the informal nature of the migrant day care support program in the past, information on the number of migrant families served, need, cost, and so forth, is not available for use in the necessary needs assessment process.

Education

The Title I Migrant Education program in Washington serves nearly 16,000 youths in 50 school districts at an average annual per pupil cost of $230.19. Almost one-fourth of these students are enrolled in Yakima County schools. More than 400 preschool children participate in Title I Migrant day care; 339 children are in secondary school programs. It was estimated that at peak season, migrants comprise between two percent and five percent of the enrollments at the schools that have Title I Migrant programs. Migrants stay in the schools one to two months each year, and most schools have some migrants enrolled six months of the year. The Migrant Education program in most participating LEAs utilizes individualized resource rooms to provide intensive, individualized tutoring, usually in reading and mathematics. Three LEAs in the state are eligible for a Title I Migrant program but do not offer the services, affecting 97 children. Of a statewide total of 69 migrant education teachers and 151 teacher's aides, 9 of the teachers and 86 of the aides are former migrants. The staff/child ratio statewide is 1:72.

The program contracts with NRO, the farmworker organization in Washington, to provide preschool services through the day care/child development centers that NRO operates. Title I Migrant staff assert that this contract relationship results in less control over the educational content of these programs than is desirable. Also, the NRO day care program is held in trailers and other facilities. Preschool education, however, is not currently a priority of the state education agency.

Summer migrant programs generally are in session for six to eight weeks. In many areas, the farmwork season lasts 12 to 16 weeks. As a result, during much of the summer, there may be no structured daily activity for migrant school-aged children. During the school year and especially in the summer programs, few Title I Migrant programs make adequate arrangements for before- and after-school care.

A number of supportive services are offered with the educational services of Title I Migrant programs. Various LEAs operating Title I Migrant projects often contract with migrant health clinics or local county health departments to provide screening and necessary medical care for migrant children. Contracted services such as these are not always provided and, in fact, pose a problem because adequate health care must be available to meet the special educational needs of the migrants enrollees, but arrangements are made by local option. In fact, prior to 1976, LEAs were required to prove their migrant child health care needs were greater than could be met by regular school health staff in order to use part of their Title I Migrant funds for this purpose. Only 29% of the children in the state Migrant Education program receive health treatment, 2,600, or 22% receive health screening, and 21% receive dental care. The dental services are noteworthy since dental care is often not available to children in Title I Migrant programs in any state. Two of the 50 school districts with Title I Migrant programs operate USDA breakfast programs, and these serve 250 children. The migrant education program includes outreach to schools and to students. Negotiations have been undertaken with the three LEAs that qualify for but do not offer Title I Migrant programs. A local farmworker organization offered to operate a migrant education program for one summer, and thereafter the LEA decided to offer the program.

Use of the Migrant Student Record Transfer System in Washington is tied to the state Migrant Education Identification and Recruitment Program (MEIRP). Through this program, designed to maximize the number of eligible students who are enrolled, the number of students enrolled was increased from approximately 11,000 to the current 16,000 between 1973 and 1976, almost a one-third increase. Unfortunately, participating schools do not find that the MSRTS is effective. The state director of migrant education has been involved on the national level in designing and implementing a revised educational records form used in the MEIRP system that would present more clearly the level of student achievement for use by the receiving school in placing the child.

The Washington program for parental involvement in Title I Migrant projects is quite strong. A state-level Parent Advisory Council actively reviews programs and policy, and has specified, in a recommendation adopted by the state office, that any project in the state must have 50% bilingual staff and use only bilingual aides. Eleven of the 18 members of the PAC are former migrants. The state office has assigned one person the task of traveling around the state to ensure that all LEAs have active and functioning parent advisory councils. The participation of present or former migrants on these councils is only recommended, not required.

The Title I Migrant Education program is large, community based, and serves migrants in many ways. Improved methods for using the MSRTS, a more comprehensive health component, and continuing efforts to involve migrant parents in the program are needed. Many preschool services are provided through NRO, but the lack of any Migrant Head Start projects in the state plus pressures to provide services only to school-aged children constrain funds that could otherwise substantially improve the size and quality of this program component.

Health

The health division of DSHS is the major provider of health care to migrants in Washington state. Health services normally reach migrants through migrant health clinics and county health departments. Primary health care and clinic services are provided to migrants through the migrant clinics while county health departments provide migrants with community health services, such as screenings, immunizations, and treatment for some communicable diseases. Out-patient care not available at the migrant health clinics is provided through referrals and is paid for by the migrant clinics.

The most extensive statewide health service for migrants is the WIC, the Women, Infants, and Children nutrition program. Approximately 1,400 slots are available to migrants on a targeted basis, serving nearly 3,500 mothers, infants and young children throughout Washington. Most of the WIC services are provided through migrant health clinics, but migrants also make use of some slots allocated to county health departments as well, especially during the peak season.

The DSHS Office of Child Health section funds a comprehensive preventive dental health program for 1,500 migrant children aged five to twelve through the migrant health clinic in the Yakima Valley. This project includes a dental education component that reaches 2,900 migrant children. State funding for the dental health program totals $111,500.

The Medicaid EPSDT and Maternal and Child Health (MCH) programs are available to migrants through migrant health clinics and county health departments in the state. The MCH program serves fewer people than the WIC program.

The health education unit of DSHS, formed in 1974, is a small office that provides materials and information to local care providers but does not support a network of health educators per se. The unit has been developing materials, including movie cassettes and pamphlets in the areas of nutrition, immunization, and parenting. This office recently made arrangements to translate many of its written materials into Spanish, using the Governor's Office on Mexican Affairs.

Outreach services to increase migrants' access to health care are provided primarily by migrant health clinics. The Yakima County migrant clinic, for example, employs six outreach workers. County health departments have only a limited outreach capability. The public health nurse in each county can provide some outreach services and may occasionally work in migrant camps.

The DSHS Health Resources Development office, in conjunction with both the Office of Family, Children and Adult Services and the Office of the State Fire Marshal, conducts inspections of day care centers for licensing purposes. Since 1968, licensing standards have been the same for centers that provide infant care as for centers that serve only children over 30 months of age. Short-term centers, which often have fewer resources than year-round facilities, must also meet the same licensing requirements. As nutritional and environmental problems peculiar to migration affect the health of migrant children, efforts are made during the licensing field work by the Office of Family, Children and Adult Services to provide nutritional counseling to center staff.

Additional Services

The Governor's Inter-agency Task Force for Agricultural Workers operates as a fact-finding arm within the state government. The primary function of the Task Force is to conduct research for the Governor on agricultural workers. The Task Force has completed research on such subjects as the economic impact of illegal aliens and the prevalence of Canadian Indians in the intrastate migrant farmworker population. These investigations provide useful program planning information. The Task Force is comprised of representatives of DSHS, the State Patrol, the State Employment Service, and the Department of Labor and Industries.

Conclusion

In summary, programs in Washington state from which migrant children benefit are sponsored by many different agencies. The result is a comprehensive, if somewhat uncoordinated, service network. Unfortunately, lack of coordination, combined with the limited size of each of the programs described, leaves both programmatic and geographic gaps. These gaps could be closed through the establishment of a local council on migrant and seasonal farmworkers, comprised of all major service providers which could facilitate coordination and a more efficient use of agency resources such as transportation and emergency food and supplies. There is a particular need for such a council to coordinate northern and southern Yakima County programs.

The present implicit state policy toward migrants acknowledges the need for some special services, but stops short of endorsement of formal programs involving needs assessment, provision of technical assistance, and program evaluation for improvement. Improved advocacy for migrant programs could be initiated through conferences, hearings, and other methods of raising staff and public awareness of the problems and effectiveness of state migrant programs. The Governor's Inter-Agency Task Force for Agricultural Workers is capable of initiating such interaction.

PART FIVE

ISSUES CONCERNING MIGRANT CHILD WELFARE

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CHAPTER I

SELECTED ISSUES IN SERVICE DELIVERY

Undocumented Workers

There is no accurate estimate of the number of undocumented workers who have illegally crossed the borders into the United States and are earning wages in this country. However, nearly one-half of the persons apprehended by the Immigration and Naturalization Service (INS) in 1972 have been employed in agricultural work (Pennsylvania Farm Labor Project, Pennsylvania Farm Labor Plan, Philadelphia: American Friends Service Committee, 1976, p. 132). Although most of the undocumented workers concentrated in the southwestern United States are from Mexico, many are from other developing countries with growing populations and high rates of unemployment.

In most of the states surveyed, one or more persons were able to provide a rough estimate of the number of undocumented workers in the study region. Estimates of the proportion of undocumented workers in the migrant work force range from less than 1% to 60% or 70% in various states. The wide range of these estimates correlates in part with the likelihood that the responding agency would encounter illegal aliens. For example, if a county welfare department is popularly known to screen for eligibility, the staff might encounter fewer illegal aliens, and give estimates in the lower range, than would the local farmworker organization which illegal aliens might contact with less fear of being apprehended. Another factor contributing to the widely disparate estimates is location. The states of California, Colorado, Florida, Texas, and Washington predictably reported rather large numbers of undocumented workers in the migrant streams. In several other states, it was impossible to obtain any estimates of the number of illegal aliens.

Undocumented workers cross the border as economic refugees who are seeking employment and are willing to accept lower wages, thus depressing the labor market and opening the way for exploitation. The workers cannot complain about working conditions or low wages for fear of drawing attention to their illegal status. For example, it was reported in two states that some ranchers prefer to hire illegal aliens because they can pay them significantly less than other workers--at a rate of one dollar per hour in one reported case. It was also reported that Immigration and Naturalization Service personnel sometimes are aware of the employment arrangements between local growers and illegal aliens, allowing them to remain until the end of the season. Growers then contact local INS officials to deport the workers. Respondents indicated that the workers' wages frequently are illegally confiscated by either INS or the growers.

Low wages and poor environmental conditions contribute to the extremely high level of need for social and health services among migrants while the migrant lifestyle makes it difficult to receive adequate and continuing services. Illegal aliens' needs for services are even greater than for other migrant workers as conditions of employment are often much worse, wages are lower, and housing conditions are injurious to family health. Furthermore, undocumented workers cannot protect themselves from exploitation or bargain with employers for better working conditions. In Washington state, the workers live in the orchards, remaining isolated from the surrounding communities.

The problems undocumented workers encounter in trying to receive services are also greater than for other workers. Most departments of social service or public welfare screen applicants for eligibility, which is normally based on proof of U.S. citizenship. Screening has become a controversial issue as it is often applied in a discriminatory manner. In one state, people are screened if staff members feel that they have too little or too much documentation for eligibility. It was reported that in several states eligibility screening is only conducted when applicants are thought to exhibit the physical characteristics of certain ethnic groups. Thus, Mexican Americans and members of other minority groups are sometimes subjected to a longer and more difficult process in applying for and receiving services. This represents an infringement of the rights of citizens, and is an affront to members of minority groups.

The effects of the screening process on service delivery are felt even in programs that do not conduct eligibility screening. It was found that, typically, there is no citizenship screening for certain services, such as those at health clinics, public health services, and protective services. Anyone in need receives help. As one public health official noted, the provision of health services benefits U.S. citizens in general since it may prevent the spread of communicable diseases. The fact that such services are available to anyone does not necessarily guarantee that people will utilize those services. It is difficult for illegal aliens to become citizens if they have been on welfare; thus many undocumented workers are discouraged by legal aid personnel from applying for social services. It was found that fear of being reported to the authorities prevents many workers from seeking help from even those agencies or service components that do not conduct eligibility screening. For example, illegal aliens in California were afraid to participate in the camp nutrition program sponsored by the local Community Action Program. It was reported in one state that fear of being apprehended has been a problem and frustration to caseworkers in protective services because it limits the usefulness of the agency in serving needy families. Farmworker organizations take various measures to circumvent the problem of fear and make services available to undocumented workers. Staff members in such organizations usually know if a person or family has entered the United States illegally and refer those families to church organizations and rural legal service groups for assistance rather than to public welfare departments which might involve law enforcement officials.

Low income families, whether citizens or legal aliens, are those most affected by the competition for jobs with undocumented workers. A recent study by the Domestic Council Committee on Illegal Aliens found that low-income families are more adversely affected by strains placed on health, welfare, and public systems by illegal aliens than are other economic groups (Goshko, John M., "Illegal Alien Study Urges Rethinking on Immigration," The Washington Post, 9 January 1977, pp. A1, 9). Several service providers in a number of states affirmed this finding. Many service program budgets are based on the number of needy, legal U.S. citizens within a county or state. The concern was expressed in Texas and California that the recent devaluation of the Mexican peso would cause many more illegals to try to cross the border, and thus create a burden on the service delivery network in those states. In states where the presence of undocumented workers was reported already to be a problem, service agency representatives felt that it was a federal responsibility--not state or local--to resolve this crisis.

Various measures taken to address the problems created by the presence of illegal aliens raise some important issues for U.S. citizens of Hispanic background. Frequently, Mexican Americans or other Hispanics of the domestic work force are thought to be illegal aliens, and thus law enforcement becomes complex. "Dragnet" raids are conducted by the INS, and workers are frequently picked up only on the basis of appearance. Detention based solely on appearance clearly violates the rights of citizens who must prove their citizenship. Other law enforcement procedures have included random car checks, harassment, and even the arrest of U.S. citizens. Rather than resulting in the establishment of rigorous screening procedures, pressure not to hire undocumented workers may result in the curtailment of the employment of U.S. citizens of Mexican descent.

Several states are currently proposing more stringent and equitable legislation regarding undocumented workers. Proposals pending in the state of Florida would make it a misdemeanor knowingly to employ, or aid in employing, illegal aliens. Further steps could be taken to make it illegal for employers or crew leaders to exploit these workers, thereby removing the incentive to hire illegal aliens. Also, a more viable and economically feasible alternative to deportation of undocumented workers is needed. Providing "free" trips home each year is costly and offers no permanent solution. Procedures could be implemented to help families already working in the United States to become citizens. Along with more stringent border control, these procedures would offer more humane treatment for citizens and undocumented workers alike.

Advocacy

In working to secure for migrants the same rights and privileges accorded to other citizens, farmworker advocacy organizations are essential to the well-being of migrant farmworkers and their children who frequently encounter discrimination and adverse reaction from community residents. The causes of these problems involve ignorance of the contribution made by migrants to the communities where they work and a misconception of the unique migrant family lifestyle and needs. Other advocacy services include easing tensions within communities, helping agencies prepare for the seasonal arrival of migrants by coordinating outreach, exchanging information with service providers, and working with agencies to avoid duplication or gaps in services.

Migrants often do not receive services for which they are eligible. Also, negative community attitudes hinder agency service delivery and minimize support which might be provided from other sources. Migrant families are isolated, are housed in migrant camps in rural areas, lack access to transportation, and, as transients, may lack knowledge of services in the communities in which they work. Migrants also experience discrimination as members of minority groups. Advocacy organizations foster good relations within communities, local social service agencies, and education or day care programs to enable migrants to benefit from needed services.

Advocacy for migrant child welfare has become increasingly important with the advent of Title XX as the major source of funds for child welfare services. A recent survey of child welfare service delivery indicates that that funding is usually granted to the best organized or most vocal group (U.S. Department of Health, Education, and Welfare, Child Welfare in 25 States--An Overview, Washington, D.C.: HEW Office of Child Development, 1976, p. viii). This is due to the emphasis on local planning and public review as a condition for Title XX funding, and to the ceiling on funding levels. Thus, there is intense competition between various advocacy groups that lobby for special services for specific subpopulations. Uneven service delivery, with disproportionate allocations to certain programs, is a likely consequence of such a funding structure. Mobile and scattered widely across many states, migrants may be unaware of the process for requesting funds and not in the region where they would need services during critical funding decision periods. The social services funding process and characteristics of the migrant lifestyle make the existence of advocacy organizations crucial as they operate year-round and are knowledgeable about migrant needs. Also, they can vocalize migrants' needs to the legislators, community leaders, and other decision makers at the appropriate times and thus help offset the political impotence of migrant families.

The principal advocates are the various state farmworker organizations, such as the Illinois Migrant Council and United Migrants for Opportunity, Inc., in Michigan, which operate only within the confines of one state, and the Texas Migrant Council, in the mid-continent stream, and Migrant and Seasonal Farmworkers, Inc., on the East Coast, which operate programs in several different states. Some of the services provided by the farmworker organizations include public awareness, outreach, recreation, health services, welfare assistance, bilingual programs, day care under Title XX and CETA, conferences, newsletters, and position papers concerning issues of importance to migrant families.

Farmworker organizations usually have a state office, and field offices near the migrant work areas. Typically funded with Department of Labor (DOL) CETA-303 monies, they operate employment and job training programs and other support services, including day care, emergency aid, and transportation. However, CETA's stated priorities are adult training and employment, whereas day care and other needed services are defined as supportive in nature. Because farmworker organizations are dependent on CETA funding, their priorities must be in harmony with those for which they are funded and evaluated; and funding to provide or coordinate many services needed by migrant families is extremely limited. As noted in the Ninth Report of the National Advisory Council on Economic Opportunity, DOL has emphasized employment programs to the exclusion of other vitally needed services that it was authorized to provide (National Advisory Council on Economic Opportunity, Ninth Report, Washington, D.C., March 31, 1977, p. 80). Most of the farmworker organizations surveyed reported that their biggest problem was the lack of funding for essential family support services. Examples show that day care services are limited and funds are needed for transporting the bodies of migrants who died while in-stream back to their home base state.

Many farmworker organizations receive additional funding from federal agencies other than DOL. Several advocacy groups operate Migrant Head Start Programs funded by the Indian and Migrant Programs Division of the federal Office of Child Development (OCD), and teacher training programs similar to the Child Development Associate programs, funded by OCD.

The overall effectiveness of the farmworker organizations and the degree to which they are helpful to farmworkers was found to vary from state to state. Some organizations, active in community relations work, have sponsored conferences, published newsletters, and conducted media campaigns. Such activities often go hand-in-hand with preseason visits to migrant camps and work areas, coordination with various local resource groups and with employers. Farmworker organizations which develop outreach activities usually benefit from good public relations as is the case with the Colorado Migrant Council. Several organizations in other states, however, are regarded as radical, "anti-grower" groups, allowing the farmworker organizations very little leverage in securing better or more extensive services from social service agencies. Under such circumstances, representatives of social service agencies assert that farmworker organizations are uncooperative. Most farmworker organizations participate in migrant service councils which meet monthly to coordinate programs and exchange information about needs and available services. However, the degree to which farmworker organizations coordinate services for migrants varies from state to state.

The National Association of Farmworker Organizations (NAFO) provides information to the state level farmworker organizations and acts as an advocate for migrants on the national level. NAFO carries out research projects, holds conferences, and produces position papers about issues of concern to migrants nationwide.

The Migrant Family Survey in this study showed that migrant families turn to the farmworker organizations for help as often as they seek assistance from members of their own families (51.8% vs. 51.4%, respectively). Thus, farmworker organizations appear to be viewed by migrant families as effective and helpful advocates.

Other organizations or agencies also have advocacy functions. In nine of the twelve states surveyed, state migrant affairs offices or coordinators within the state governments act as ombudsmen. They serve to coordinate agency efforts at the state level and to make agency personnel more aware of migrants' needs. Some migrant affairs offices conduct research projects assessing migrant family needs and the effectiveness of service delivery. Training and technical assistance have been provided to organizations or individuals wishing to start migrant day care programs. The extent to which coordination is facilitated by migrant affairs offices varies according to the abilities and concerns of their staff, and of people in other agencies which serve migrants. Also, migrant affairs offices are housed within different agencies in the various states. Some are located in the Governor's office; one is in the Office of the Secretary of State; several are within the departments of social service; and others are in the departments of labor. It may be that the sphere of influence of these offices is limited or expanded by the location within the state government. A migrant affairs staff in the state Department of Social Service may be more concerned and have more influence over child welfare and other social service policies affecting migrants whereas Department of Labor staff may devote more time to CETA-related programs and worker problems. Placement within a specific agency may also affect the efforts and effectiveness of the offices in coordinating services provided by different agencies. Offices of migrant affairs located in the Office of the Governor may be in a better position to coordinate agencies and have more objectivity in legislative recommendations.

Legal aid programs are actively serving migrants in several of the states surveyed. While legal support may not seem to be a service which directly affects the immediate physical and psychological needs of children, there are many cases in which judicial decisions do affect a child's well-being and future. Also, legal aid does have long-range impact on the entire migrant population. The scope of these problems affects all areas of migrant life, including nutrition, education, and the level of wages earned by the family. According to Vice-President (then Senator) Walter Mondale: "Running all through the problems of (migrants)...is the fact that they are so impotent politically that there is no requirement, no need, to respond to their legitimate requests..." (U.S. Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Migratory Labor, Hearing on Migrant and Seasonal Farmworker Powerlessness, Part 3-B: Efforts to Organize, 91st Congress, 1st Session, 15 July 1969, p. 895). Migrant child welfare is inevitably dependent upon, and inseparable from the political condition of the whole migrant farmworker population.

Legal aid programs, such as the Michigan Migrant Legal Action Program in Berrien County, Michigan, have been developed specifically for migrant farmworkers. Rural legal aid offices, such as the Colorado Rural Legal Service, may have a staff lawyer who handles only migrant clients. Several farmworker organizations also have had staff lawyers.

Law suits brought by migrant legal aid programs often evoke a negative reaction; community tension was reported in several of the states surveyed. Frequently, legal aid personnel bring suit in the areas of housing or food stamps provisions against local growers and social service agencies. In such cases, the growers feel that legal aid personnel are working in opposition to them.

Many legal aid programs are funded by the Legal Services Corporation (LSC). One of the LSC grantees has been the Migrant Legal Action Program (MLAP), a significant advocacy group for migrant and seasonal farmworkers. The MLAP headquarters in Washington, D.C. functions as a national support center for the representation of migrant and seasonal farmworkers by rural legal service programs and monitors the enforcement of federal protective legislation and regulations nationwide. The bilingual staff also provides legal information and referrals. MLAP personnel have testified on behalf of migrants before Congressional committees. MLAP circulates information valuable to farmworkers and their advocates through the monthly publication "Earthbond."

Other advocates were found to be migrant ministries or church-affiliated persons serving migrant interests. The East Coast Migrant Project, the DelMarva Ecumenical Association, and the Berrien County Council of Churches are among those included in this category. Church-affiliated organizations often donate the use of their buildings for day care or recreation, provide free clothing, and contribute to the delivery of other needed services. Some actually administer day care programs and provide health services in several states. This is true of the East Coast Migrant Project.

In addition, there are several nonprofit organizations operating special programs for migrants. One of the best examples is the program at the New York State Migrant Center in Geneseo, New York, which provides day care, vocational training, in-camp learning, recreation, and other activities for migrant children and adults.

The effectiveness of advocacy organizations depends to a large extent on their abilities to work with, rather than against, their adversaries. Some advocacy groups are becoming more aware of the value of reaching a mutual understanding with growers and social service agencies. Given the greater political leverage and community influence of growers and local government personnel, the success of advocacy groups depends, in large part, on the support of the community. It is necessary for migrants, their representatives, community residents, and officials to have a cooperative working relationship and to attempt to reconcile problems or difficulties before legal action becomes necessary. If community officials and farmworker advocates work together, problems which are detrimental to all concerned may be averted. Currently, however, migrants need the protection and advice of legal groups, the aid and cultural understanding of farmworker organizations, and the political representation of all advocates to assist them in obtaining needed services. Without these groups, migrants' needs will go unvoiced and unserved.

CHAPTER II

TRAINING OF FARMWORKERS IN SERVICES TO MIGRANTS

The Nature of the Problem

The delivery systems for social welfare services should ensure that all eligible groups have access and receive those services equally. However, cultural, racial, and linguistic barriers frequently interfere with the delivery of welfare services. This problem is particularly severe in the case of migrants due to their mobility in-stream and physical and social isolation both in-stream and at the home base. To a great extent, these problems in social welfare agencies can be overcome by employing staff members who were themselves migrants. Such persons would have a greater empathy for the client population, a fuller understanding of the problems of migrants, fluency in the language of migrants, as well as a deeper familiarity with the cultural and ethnic backgrounds of the migrant population. Not only would the problems of migrants be better understood, but also the migrants should be less hesitant to seek help from social service agencies knowing that the personnel are of the same background.

Social service agencies experience some problems in recruiting migrants or former migrants for their staffs because the pool of qualified individuals appears to be small. Migrants generally have difficulty in leaving the migrant stream to receive the education and training necessary to work in the social services field. Further, of those who do receive the necessary background, there is no assurance that they will work in social service agencies with migrants. The purpose of this chapter is to determine whether there is a pattern or system of training migrants for social service work and of employing them in social services provider agencies that serve migrants.

Methodology

Two major methodological tasks were involved in investigating the training and employment of migrants for work in the delivery of social services to migrants. First, it was necessary to define and identify programs oriented toward the goal of employing migrants in social services provider agencies. Second, a questionnaire was designed to elicit information about the programs identified as relevant to this investigation. The methodology utilized in completing these tasks is discussed below.

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Identification of Relevant Institutions

Relevant programs were defined as those with a pattern of recruitment and training of former migrants for employment for working with current migrants who are clients of social service agencies. This definition was restrictive by design to concentrate the investigation on appropriate programs. An attempt was made to determine whether there exists a pattern of programs that meet this definition partially or fully. For instance, some programs might recruit migrants to work in social service fields but might not necessarily place them to work with current migrants. Other programs might recruit people from the general population to work with migrants.

Institutions of higher education and Department of Labor programs under the Comprehensive Education and Training Act were identified as the most likely sponsors of relevant programs. In addition, some local programs not directly related to institutions were known to recruit and train migrants for service delivery to current migrants. These three types of organizations were then contacted.

Institutions of Higher Learning - Initial contact with institutions of higher learning was restricted to large state universities, since these universities had technical programs that were relevant, and since personnel at these schools would be most likely to be aware of programs in other institutions. Four state universities were chosen on the basis of their geographic location and the large migrant population in those states. State universities in California, Michigan, Texas, and Washington were contacted. A minority affairs officer was contacted to determine whether his university housed a training program that even partially met the definition utilized in this study. Queries were also made concerning recruitment of migrants, follow-through contacts, training programs in other institutions and related issues. Next, similar calls were made to universities and colleges identified by the first four institutions as having programs that might be relevant. In general, it was found from these initial contacts that institutions of higher education often have Chicano Affairs offices, minority affairs offices, Mexican American programs, educational opportunity programs, or other programs that recruit and assist Chicanos or Blacks. Migrants are served through these programs when they happen to fit into one of the target groups. Students recruited for training are usually dispersed throughout the institution in various fields of study, some of which may be the social service area. Typically, there are no organized migrant training programs and no specific coursework for migrants. In addition, there is no guarantee that graduates will work with migrants.

Department of Labor - Manpower training specifically for migrants and seasonal farmworkers is provided by the Department of Labor under Title III-B, section 303, of the Comprehensive Education and Training Act. The purposes of CETA manpower programs for migrants are to assist migrants and seasonal farmworkers who wish to leave agricultural jobs, and to provide services to improve the well-being of migrants who remain in the agricultural labor force. Classroom training, on-the-job training, and work experience with a nonprofit agency are all provided. CETA training programs, however, are not aimed at providing migrants with skills so they can work in providing social services to other migrants. Some CETA 303 programs do take a few migrants and train them to work in assistance programs for migrants. The best example of this is the training of day care aides, although most of this type of training is informal or on-the-job training. Such slots are also filled on an as-needed basis, rather than through scheduled training classes. The same is true of HEW-sponsored migrant health programs which train health aides on an occasional basis.

Local, On-the-Job Training Programs - Other types of training programs involve on-the-job training, such as training to become teacher's aides. It is possible that some of these programs regularly recruit migrants to work in their service delivery components which serve migrants. The best-known example of this type of program is the Head Start Supplementary Training program which trains enrollees to work in Head Start programs. Although trainees work with migrants, graduates of this program will not necessarily continue to work with migrants. An attempt was made to determine whether other programs of this nature, such as training programs in migrant day care centers, recruit migrants who later are employed in service to other migrants.

The final list of institutions and training programs to be contacted was constructed. This list was based on programs suggested through telephone contacts with these three types of organizations and additional information obtained through other project work.

Questionnaire Design

The training institution questionnaire was designed to elicit responses from any program that exhibited, at least partially, a pattern of recruitment and training of former migrants for working with current migrants who are clients of social service agencies. Respondents were asked to describe various dimensions of their programs. These included recruitment procedures, entrance criteria, funding sources, curriculum, faculty composition, student profile, attrition rate, work experience training, employment of graduates, and follow-up contact. Respondents were also asked to name other institutions or service agencies which might have programs meeting the migrant social service training criterion. This allowed for more complete coverage of possible sponsors of training programs.

The first wave of questionnaires was sent to almost 70 institutions who were identified as administering programs which would potentially meet the training requirements. The second wave of 19 questionnaires was sent to additional programs identified by the first wave and through additional contacts.

Survey Findings

A total of 89 questionnaires were distributed. Of these, only 23 were returned. Very few of the returned forms indicated the presence of programs relevant to the study of social service training for migrants. It can be assumed with some certainty that those institutions which did not return the questionnaire do not have relevant programs. Thus, there is clear evidence that no broad pattern exists of recruiting and training migrants to work in social service agencies, either to work with current migrants or with the population in general. In fact, most programs or training institutions reported that they had no idea whether any migrants were enrolled. A few programs did keep records on migrants enrolled, but most did not know which specific programs the migrants were studying or what type of employment the migrants would seek after graduation. In this sense, the results of this survey were disappointing.

Model Programs

Despite the limited number of responses to the survey, several outstanding programs for training migrants were brought to light. These programs varied in nature and in organizational sponsorship. Model programs for migrants include the training of migrant adults to provide educational services to migrant children at the home base and while in-stream or traveling, the utilization of migrant college students to teach migrant children in summer programs, the preparation and certification of migrants to be teacher's aides, and a university for farmworker students only. These programs are described in detail below.

Training Migrant Paraprofessionals in the Bilingual Mini Head Start Educational Services District 104, Grant and Adams Counties, Washington -

Educational Services District 104 of the state of Washington operates a program designed to determine the results of training adult migrants and supplying them with curriculum materials so that they can provide bilingual educational services to migrant children. The adult former migrants working with the children have had no previous teaching experience, and for the most part, they have had only a limited education. This program provides intensive in-service training in both curriculum materials and teaching methods. In addition, arrangements have been made for the migrants to take college courses, and, for those who need it, training to receive the General Equivalency Diploma. The Educational Services District has set up two year-round centers in Washington state. Another component of the program operates in Texas during the time when migrants are at their home base. The trainees travel with the migrants and continue to provide educational services to the children as the families move.

This program appears to have demonstrated conclusively that adult migrants can be trained to provide a superior bilingual educational service to migrant children. The program was selected by the Dissemination

Review Panel of the Board of Education as being among the first that was able to document significant educational gains for the children served. Reports have shown that the children made statistically significant gains in mathematics, reading, language development in Spanish and English, and a knowledge of Mexican and U.S. cultures. Another advantage of this program is that there is no pressure to place graduates quickly. Pressure for quick placement sometimes leads to placing former farmworkers in positions that provide no improvement in pay or working conditions over farmwork. Rather, this training program allows former migrants to remain as long as they need to develop fully their teaching skills. Another favorable result is that the graduates of the program are dedicated to serving migrants.

California Mini Corps - The California Mini Corps is a part of the California Plan for the Education of Migrant Children, a program which operates special summer school sessions for migrants. During the summer of 1976, the California Mini Corps operated student assistance programs in approximately 60 school districts. Mini Corps was developed to fill a need for school staff who were close to migrant children in language and background. Young teachers who had been migrants themselves are recruited to fill this need. This program is sponsored by the State Department of Education, Bureau of Community Services, and is funded by Title I, ESEA.

At present, Mini Corps training programs are conducted at four sites: Indio, in cooperation with Region VII of Title I Migrant Education; California State College, Bakersfield; California State University, Chico; and California State University, San Diego. To be eligible for Mini Corps, a student must be enrolled full time in an institution of higher learning, need financial assistance, be bilingual (Spanish and English), have knowledge of the migrant lifestyle, be single and between the ages of 18 and 24, and be dedicated to teaching migrant children. Students receive a stipend based on the amount of time spent in service to migrant children. Mini Corps students enroll in a one-week orientation seminar that discusses community agencies, teaching techniques, and problems of migrant families. Students then work as teacher assistants in a summer classroom for six to nine weeks. Afterwards, a one-day post-service evaluation is conducted. Students receive three units of college credit for their participation in this program. Students thus thoroughly familiarize themselves, or re-familiarize themselves, with the problems of the delivery of educational services to migrants.

Geneseo Migrant Center, State University College, Geneseo, New York - The Geneseo Migrant Center at the State University College, located in rural New York state, serves migrants and other rural families, as well as educators of migrants. There are three relevant training programs for migrants: training of teacher's aides, vocational education, and adolescent outreach. The number of migrants in each program varies with the season. Generally, there are between 10 and 40 migrants in the teacher's aide and vocational education programs and up to 150 migrants in the adolescent outreach program.

The teacher's aide program is the one that most closely fits the definition of social service training programs for migrants. This program prepares and certifies migrants to work as teacher's aides. The training program lasts for six weeks; and the migrants earn $2.30 per hour during training. After completion of the program, almost all of the migrants who find employment as teacher's aides work in positions in which they serve other migrants. The graduates usually are employed in migrant day care centers or in schools with migrant students. The Migrant Center also runs migrant children's programs in which the teacher's aides may find employment. However, graduates of this program frequently have difficulty securing employment because they must compete with applicants who have college degrees.

Other Geneseo Migrant Center projects that serve migrants include vocational education and adolescent outreach programs. The vocational education program utilizes mobile units to provide classes in career exploration, automotive repair, and construction in migrant camps. The adolescent outreach program attempts to retain potential dropouts and to encourage migrant dropouts to return to schools. Students are exposed to a wide range of career alternatives and provided with the basic skills to secure employment in the existing labor market. Some of the graduates of this program remain in farmwork, but they are usually able to upgrade their pay and increase their responsibilities because of training.

Follow-up is provided on an informal basis. Personal contact by staff members is made periodically if the farmworker settles in the area. If the farmworker settles elsewhere, the staff maintains indirect contact through farmworker programs and agencies in that area.

Universidad de Campesinos Libres, Inc. (UCLI) - the Universidad de Campesinos Libres, Inc., is a new university established in 1973 especially to serve farmworkers. It is private, bilingual, four-year, degree-granting institution of higher learning located in Fresno. The university is governed by a Board of Trustees, the majority of whom are farmworkers drawn from the farmworker community of the greater San Joaquin Valley. The student body is primarily from the Valley community and predominately Mexican American. Eighty percent of the faculty members are themselves former farmworkers.

The university has an ongoing recruitment program operated through high schools and various community agencies. Students are required to have either a high school diploma or a General Equivalency Diploma (G.E.D.) (or a comparable education or certificate from Mexico) and must be farmworkers. Because the tuition is $1,000 per semester, almost all students are on a college work-study program, which allows students to work in a public or private nonprofit organization at $3.00 per hour. Other forms of financial aid are also available. Contact will be maintained with all future graduates, and follow-up will be provided through newsletters and other forms of communication.

Despite the farmworker backgrounds and orientation of students, faculty, trustees, and programs at UCLI, there is no assurance that graduates will work with other migrants. This is not a priority of the program, but it appears that many of the graduates do want to work with other migrants after graduation. However, as the program is only in its fourth year of operation, no students have graduated, so the type of employment the graduates will seek cannot yet be determined.

Other Training Programs

The survey found various other programs that, to some extent, provide social services training for migrants. None of these programs, however, regularly recruits migrants or systematically places them to work with other migrants. However, these programs have some components that involve training or placing migrants to serve other migrants. A sampling of the types of programs currently offered follows:

Mabton Project, Washington State University - The Mabton Project enrolled a total of 140 migrant students in the 1975-76 academic year in basic education courses, including reading, mathematics, articulation, English as a Second Language (ESL), and consumer education. Preparation for the G.E.D. is also offered. The Mabton Project recruits migrants through flyers and extensive use of the media, as well as through coordination with other agencies. The primary purpose of the project is to provide a solid educational background to migrants through improving their own self-concept as well as through providing basic education. However, no attempt is made to train migrants for specific jobs or to encourage them to work with other migrants.

Child Development Associates Program, Texas A & I University - Texas A & I University has a bilingual/bicultural Child Development Associates (CDA) program to prepare people for working with preschool-aged children. The university also administers vocational training programs aimed at former migrants. A total of 410 migrants were enrolled in these programs in academic year 1976-77. The program works in close coordination with the Texas Migrant Council and Coastal Bend Migrant Council, as well as with drug abuse and employment agencies. About 50% of the migrants are taught by faculty members who are themselves former migrants. However, migrant students are reported to have difficulty in some basic classes, especially English. Although there is CDA training as well as training to be research or laboratory assistants, clerks, and tutors, only about five percent of the graduates ultimately obtain jobs that directly serve other migrants.

United Migrants for Opportunity, Inc. - United Migrants for Opportunity, Inc. (UMOI), a private, nonprofit farmworker corporation in Michigan, sponsors a Migrant Scholarship Program jointly with participating colleges in Michigan. Eligibility for UMOI scholarships is limited to farmworkers, defined as those who have received, or the children of those who have received, at least 50% of their total earned income from seasonal agricultural work during any consecutive twelve-month period, and are classified as economically disadvantaged in accordance with Office of Management and Budget criteria. Any U.S. citizen with a high school diploma or G.E.D. who meets these criteria is eligible for a UMOI scholarship. Of course, in order to utilize the scholarships, the students must meet the standards of the participating college or university they wish to attend. A total of 13 colleges and universities in Michigan participate under this program, and enrolled 30 students in 1976. Students are permitted to choose any major they desire, but are encouraged to major in fields in which post-graduate employment is most likely to be found. In the past, about 20% of the graduating migrants have found jobs in which they would serve other migrants, despite the fact that this has neither been required not explicitly encouraged by the UMOI scholarship program.

Conclusions and Recommendations

It is clear from this study that no nationwide pattern of recruiting or training migrants to serve other migrants exists. There are a few exemplary programs, however, but these recognize the value of having former migrants placed in jobs that permit them to serve current migrants. In general, most programs in colleges, universities, or other training institutions or programs do not systematically recruit migrants. Also, those programs that recruit migrants generally do not train migrants to serve other migrants in service or "helping" jobs but simply to leave agricultural work. Those migrants who desire to serve other migrants generally find that there are no programs aimed at helping them meet this goal.

A related problem is a lack of coordination between those few programs that do exist. These programs seem to have been developed totally independently of each other. It would be advantageous to have a central clearinghouse of information about such programs so that institutions desiring to set up similar programs could receive information and technical assistance. For example, the questionnaires returned from universities and colleges indicate that poor command of English is a recurrent problem with migrant students. Thus, it may be worthwhile to include English as a Second Language as a component of specialized training programs. A central source of information could serve to enlighten institutions as to the extent of a problem, and encourage the development of new solutions and new programs, as well as alerting organizations to potential pitfalls in programming, training, and job placements. At present, most colleges and universities seem unaware of the problems of migrants in obtaining higher education, and do not give adequate consideration to those individuals whose educational backgrounds handicap them for college-level work.

CHAPTER III

CASE STUDIES

Two situations were identified in the course of the research for this study which were determined to be of significant interest. While it is not intended to portray these as particularly "good" or "bad" situations, it is intended that, by describing them in greater detail than is possible within the format of the site chapters of Part Four or elsewhere, insight can be gained into the actual workings of programs serving migrant children, and the unique parameters within which they must operate that do not affect programs serving children in the general population.

The situations presented include a state-operated statewide day care program for migrant children and a local level situation that illustrates the impact of community attitudes on service to migrant families in any setting.

The New York State Migrant Day Care Program (NYMDC)

Described briefly in the site report on New York/Wayne County, the New York State Migrant Day Care Program (NYMDC) is operated statewide by the New York State Department of Agriculture and Markets to provide day care for the children of migrant and seasonal farmworkers in all regions of farmworker-intensive agriculture in the state. This discussion will present the operations of this program in greater detail than was possible in the site presentation, so that the complexities and benefits of such an operation can be more readily understood and, perhaps, repeated elsewhere.

Description

Begun in the 1930's as a statewide program by the Homer, New York, Council of Church Women, and adopted by the Growers and Processors Associations based in the same town, the State Migrant Day Care Program existed for many years on minimal funding with more or less custodial functions so that children could be kept out of the fields. The Department of Agriculture and Markets funded the program, but it was not until recent years that it was incorporated formally into the Department, and an administrator appointed. The budget was reviewed and the program upgraded considerably. In 1972, the budget for the program was $400,000 for 30 centers, 11 of which were in schools. By 1976, when smaller centers had been consolidated and inadequate ones eliminated, the budget was $1 million for 23 centers, only two of which were in schools. Problems of the program's growth imperiled its existence, however, when categorical improvements were made at all facilities statewide. An example was the decision to have nurses on duty at least four hours per day at each center. The cost exceeded the program's budget, and cutbacks had to be made.

Due both to a plan to obtain partial support for the program from the Bureau of Migrant Education, using Title I Migrant funds, and to the Department of Agriculture and Market's increased underwriting of the program, the Indian and Migrant Programs Division (IMPD) of the HEW Office of Child Development reduced its support from an annual figure of $100,000 to $18,000 in 1975. The $100,000 had been provided to the program through the East Coast Migrant Head Start project, and used for five nurses' salaries, transportation, and medical supplies at a total cost of $77,000 for a ten-month contract. The expectation that IMPD would expand its program had led the East Coast Migrant Head Start project to plan to terminate its operations in New York, but when the expansion did not occur it agreed to provide the $18,000 so that widespread defunding of centers would not ensue.

At present, the program receives $350,000 from an annual grant by the Migrant Education program, which pays for classroom staff salaries, educational materials, and staff training sessions. In addition to the Agriculture and Market's share, funds are derived from CETA programs for trainees as teacher's aides, from USDA food programs, occasional AFDC monies for placements by local social services offices, and, in one or two cases each year, protective services placements.

The NYMDC program currently serves 1500 children in centers usually located in churches, rented facilities, and public buildings. Two of the centers located in college settings are the New York State Migrant Center at the State University at Geneseo, which is a program with a number of components, and a center at the State University at New Paltz. Also, three of the centers operated as programs run by organizations other than NYMDC are funded on a purchase-of-services basis. The program employs 400 full and part-time staff, 20% of whom are current or former migrants usually working as aids, cooks,or bus drivers. Twenty to thirty percent of all staff are bilingual.

Most programs begin at 7:00 or 8:00 a.m. and continue until 4:00 or 6:00 p.m., which in New York state serves the needs of the migrant farmworker families. (In other states, such as California, farmwork hours may run from 4:00 a.m. to 10:00 p.m.) Seven of the centers are open year-round, serving migrant farmworker families who recently have settled-out of the migrant stream and obtained employment in the off-seasons. To keep fully enrolled in the off months, these centers accept a considerably larger number of social services-referred children than would the seasonally open centers, which need almost all their spaces for the migrant children.

The centers serve children from two or three to five years of age, although some may take children as young as one month old.

Eligibility requirements are modeled after, but differ from, those of the Title I Migrant Education program. A child must be from a family that is either currently migrating, or has settled-out within the past five years. Both parents must be either working full time, looking for work, or enrolled in a job training program.

The center programs include adherence to an educational curriculum--language development, socialization, large and small motor skill development, cognitive development, and reading readiness. The children receive two or three meals a day plus a snack, are given physical examinations and immunizations, and are transported to the center daily, and to medical facilities as needed. Center sizes vary, but a typical center of fifty or sixty children may be staffed by a director, three teachers, ten aides of which three to five are bilingual and several are usually CETA trainees, a cook, two bus drivers, and a part-time janitor, in addition to a full- or part-time nurse.

Operations

The eligibility requirement that both parents work makes it difficult to serve the children of families who have arrived in a work area. As the program broadens the eligibility base, defining "migrant" less stringently, and as farmworkers settled-out for five years or less apply for services, problems develop when centers are filled before the true migrants in the greatest need arrive. The "five-year migrants" are entitled to day care services, but their needs do not necessarily take priority. The program does have flexibility, but budget limits and center licensing restrictions limit the number of children able to be served. Another eligibility problem concerns the program's brief involvement with the federally funded portion of the Title XX Social Services program, discussed in more detail below.

A new staffing pattern for the centers has been designed and is being instituted which modifies the typical staff structure indicated above in three ways. First, it frees the center director from all teaching duties, thus allowing more intensive community liaison. Each director will be required to submit a community involvement plan. Second, it adds a staff education coordinator, accredited in curriculum planning, development, and supervision, to work in a non-teaching capacity with responsibility for the center's educational operations and training of aides. Third, it consolidates the two levels of "teacher" and "experienced aide" into one category, that of "paraprofessional," with the "entry-level aide" position retained. Qualifications are thus standardized for all centers. Many had nonaccredited persons working as teachers, despite their lack of any greater amount of training and experience than more experienced aides may have had.

This new staffing pattern formally acknowledges the obligation of each center to adhere to the educational curricula mandated for its use, and improves the opportunities for paraprofessionals by increased supervision and training. It increases outreach capability while decreasing isolation from the community. The program can work more effectively with the Bureau of Migrant Education through more clear-cut proof of educational programming and permitting easier monitoring by education field staff. In most cases, the changeover results in an upgrading of the position of many aides; unfortunately, there will be teachers who are downgraded as well. The pattern results in a substantial net budget savings in salaries, permitting the Education Department's share of the program's expense to remain level or at least to increase minimally while allowing the program to expand its capacity as needed. Under the new plan, aides will be paid at a rate of about $4,600 a year; paraprofessionals, $7,200; and the director and education coordinator, each $10,000. It should be noted that the already low salaries of teachers and a lack of fringe benefits were blamed for a relatively high turnover rate among staff. Rapid staff turnover produces recruitment problems, which, in turn, affect staffing ratios, creating subsequent licensing problems.

The education and health specialists who serve as consultants to the Agriculture and Market's day care program office augment the program's capability to work with other organizations at the local and state levels. Program Funding, Inc. (PFI), the farmworker organization, has been pressuring Agriculture and Market's increasingly in recent years to improve the quality of the day care program. A PFI staff member, hired as a Program/Education (P/E) Specialist on a personal services contract, played a central role in the revised staffing pattern, and is Agriculture and Market's key field contact. The P/E Specialist and an assistant visit all day care centers and work with the three regional directors to see that programs, such as the staffing change, are implemented smoothly. They also help to develop community awareness by attending parents' meetings and events at centers around the state, and work on problems, such as lack of transportation, uncooperative growers, lack of facilities, and poor coordination with other services providers.

While the consultant's functions are in accord with Agriculture and Market's program objectives, another consultant was hired by the Department on a one-year management review/program planning/technical assistance contract to take a fresh look at the system and incorporate many of the new procedures. Whether the entire day care program will, for example, be contracted out to PFI to run in the future has not been determined, and depends on the results of this cooperative effort between PFI and Agriculture and Markets to upgrade the program.

Administration

Three major difficulties impact on the administration of the program at the state level: the definition of the term "migrant," discussed above, which varies considerably among the several funding agencies; the complexity of the funding process, due primarily to factors of fiscal cycles; and constraints of the Title XX program.

Children already being served by a large statewide program do not all fit the specific definitions used by the funding source programs. For instance, a certain amount of "bending" of the definition probably occurs in order not to disqualify any families receiving services. This interpretation would be unnecessary if there were a federal definition of "migrant," as urged by many state and local level program operators.

The second funding difficulty involves the interacting problems of different programs being funded in different fiscal years. New York's fiscal year begins May 1st; the federal government's, as of 1976, October 1st. Other agencies with which the program must deal operate on a fiscal year beginning July 1st, and some private groups and businesses operate on the calendar year. Besides the year-round application preparation process required, a major planning problem is created in determining the total funds required and the proportion to be requested from each source. New York state supports the NYMDC program by paying the amount needed to operate the program that is unavailable from other sources. This amount is difficult to determine when the amounts available from other sources, specifically the federal government, are not known until October, well into the season when operating funds are sorely needed at the local level. There are, however, no clear-cut solutions to this problem. Separate and independent cost projections seem to be inevitable for preparation of applications to each of these funding sources with their various grant award deadlines.

When Title XX came into effect in 1974, there were several consequences for the New York State Migrant Day Care Program. Support for NYMDC was transferred from the Department of Agriculture and Market's basic budget to that part of the Department of Social Services (DSS) budget to be used as the "non-federal share" for Title XX funding calculation purposes. For the 1974 and 1975 fiscal years, therefore, the program was subject to Title XX administrative and reporting requirements, resulting in greatly complicated form preparation procedures at the local level. In one part of the state, a service agency representative said that a quasi-literate migrant mother was typically required to fill out six pages of forms for each child to be enrolled in the program. According to the director of the migrant day care program, a reason to stop funding the program under Title XX was that the large number of incorrectly completed forms were likely to be rejected at the state level, producing funding reductions. As a result, an arrangement has been made which is predicated on the fact that New York has exceeded its Title XX plan and budget for a number of years and has had to provide additional funds each year above the non-federal state funds committed when an annual plan is developed, in order to receive the necessary additional 75% federal matching funds needed. State funds supplement DSS funds until needed later in the year.

In summary, while the director of the program feels that only as few as 20% of the eligible children in the state are served by the NYMDC program, it is, nonetheless, a comprehensive statewide program for migrant child care that, through licensed, community-based centers, provides nutrition, health care, developmental potential, and emotional security for the 1500 children of the state's farmworker population, enabling their parents to work without anxiety for the welfare of their children. That this program was begun by the employers testifies to the acceptance of the premise that parents without worry for their children's welfare can work more productively. This concept is valid nationwide, although it is seldom applied so effectively as in New York state.

Immokalee, Florida

Immokalee is in Collier County in a swampy, isolated area 45 miles northeast of the Gulf Coast resort town of Naples. Agriculture is Immokalee's only real industry. Landowners, mostly White, are able to grow citrus fruit, tomatoes, and vegetables throughout the year in the region. Naples, the county seat, is a resort coastal community with a predominantly White population. Most county resources and services are centered in Naples. Immokalee has a low tax base due to the high proportion of low-income residents in the town. Immokalee shows no signs of growth, there are abandoned buildings, and the town is deteriorating.

From October to April of each year, Immokalee is home to about 14,000 interstate and intrastate migrant farmworkers. Hispanics are predominant among the migrant population, but there is a high percentage of Blacks, too. Because Immokalee is a home base, there are many more migrants there than in other areas, and migrants live in large settlements in town rather than being dispersed in labor camps. The living conditions of these migrants are deplorable. There are entire neighborhoods of thrown-together, tarpaper shacks. Some migrants live in old mobile homes. All housing is characterized by crowding, deterioration, and poor sanitation. Florida State Representative John Lewis visited Immokalee in 1976 and reported to the press, "There can't be more than 15 or 20 nice homes. The rest of the place is unbelievable."

In general, neighborhoods are divided strictly along racial lines. Blacks and Hispanics occupy separate areas in Immokalee, and Whites live at some distance from the town. Despite this de facto segregation, living conditions are equally bad for Blacks and Hispanics.

Unemployment is a persistent problem among farmworkers in Immokalee. Mechanization of agriculture has been increasing in recent years, particularly in preharvest work. The number of agricultural jobs and the duration of those jobs are progressively shrinking, and so unemployment is on the rise. Farmworkers are not eligible for unemployment compensation under existing legislation, yet employment is precarious for them because the availability of farmwork is as variable as the weather. The USDA found that, in October 1975, the unemployment rate for Collier County was just under 20% (U.S. Department of Agriculture, USDA Reports, p. 33). It is likely that unemployment within the county is concentrated in Immokalee due to the characteristics of the population. During the fall of 1976, the unemployment situation worsened. Migrants returned to Florida in the early fall due to droughts in the Midwest and floods in the South which cut short the agricultural season in up-stream states. Under normal circumstances, migrants do not return to Florida until October or November. Also, the number of farmworkers in Florida increased as migrants who normally make their home base elsewhere went to Florida in search of work. A drastic situation resulted in Immokalee. Local leaders reported that 400 unemployed people lined up each day seeking employment from growers who hired fewer than 20 workers in all. A knowledgeable source reported that conditions for farmworkers in Immokalee were the worst observed in nearly 30 years.

Unemployment among farmworkers created an urgent and rather widespread need for emergency assistance. Food stamps, of course, were among the prime necessities of the unemployed population. Even before the crisis in late 1976, migrants and nonmigrants had experienced great difficulty in obtaining food stamps. A USDA on-site visit to Immokalee in late 1975 found that food stamp applicants had to wait three weeks for their certification interviews, and that there were no provisions for certifying emergency cases in less time (Ibid., pp. 31-32). In addition, only two of the seven eligibility clerks in Immokalee were bilingual, yet approximately 90% of the caseload were Hispanic; 8% were Black; and 2%, White (Ibid., p.33).

Food vouchers reportedly became unavailable in Immokalee in August. Many local leaders reported that a statewide farmworker organization, the Community Action Migrant Program (CAMP), returned funds allocated to the organization for providing emergency food vouchers to farmworkers because the funds were not used within the time allotted. Thus, from August 1976 on, CAMP was unable to meet the critical need for food among farmworkers who returned early to Florida from a disastrous agricultural season up-stream. Beginning in August 1976, and continuing into the fall, over 300 families sought emergency assistance from Organized Migrants in Community Action (OMICA), a farmworker organization serving Immokalee. Local churches were the only source of emergency food, and OMICA was able to provide 1,300 persons with food and clothing by campaigning for donations of the supplies needed. However, OMICA and private sources of donations were unable to meet the need fully, and it was reported that some farmworkers had to go without food.

Service Providers

Services provided to migrants in Immokalee by public and private agencies are described in this report, in part Four, Chapter III "Florida: Collier County." In Immokalee, there is a greater diversity of services and of service providers working with migrants than in many other farmworker sites. This is due to the fact that there is a very large population of migrants in the town and because Immokalee is a home base for farmworkers.

There are housing programs for migrants in Immokalee. Farmworkers

Village is a low-income housing project consisting of single-family units which are inhabited and owned by migrants. The Collier County Housing authority administers Farmworkers Village and, in 1976, obtained $3,000,000 in additional funding for expansion from the Farmers Home Administration. Spokesmen for Redlands Christian Migrant Association (RCMA), an advocacy group, termed Farmworkers Village a model project. Another housing program is operated by Self-Help Housing of Florida, Inc., headquartered in Immokalee, serving Collier and Hendry counties, and funded by the Department of Labor under Title III-B of the CETA program. Self-Help Housing promotes the construction of low-cost units by having the prospective homeowner contribute his own labor to the construction, thus reducing the cost of housing. Most of the units built through this program are single-family dwellings. Self-help housing of this type offers some advantages to migrants. At the same time, self-help housing requires hard labor before and after a full day of agricultural work, demands a long-term commitment to building which may interfere with migration and employment patterns, and is too costly for some migrants.

Legal services are available to migrants in Immokalee. Florida Rural Legal Services, Inc. (FRLS), a nonprofit corporation funded by the Legal Services Corporation and other sources, has one of its four field offices in Immokalee and provides legal services to migrants, Indians, and other rural residents and also acts as an advocacy group. The Immokalee office of FRLS is open from 9:00 a.m. to 5:00 p.m. on weekdays. The organization furnishes legal assistance to individuals for civil cases in such areas as housing, welfare, consumer-vendor relations, juvenile matters, and domestic relations. In addition to serving individuals, the FRLS is acting as an advocate for rural people and for migrants in handling litigation for law reform in state and federal courts. From October 1975 to October 1976, FRLS advised and represented 8,600 individuals and 35 community organizations in its seven-county service area in southern Florida.

Additional service providers in Immokalee include the Redlands Christian Migrant Association and the Catholic Services Bureau of Collier County. There are private nonprofit organizations which not only provide services to migrants but also employ migrants on their staff and include migrants in their policy-making boards. RCMA services focus on operating day care for migrant children and acting as an advocacy group. RCMA day care programs are exceptional in that all of the staff members are former migrants, and there are many bilingual persons among the personnel. A racial/ethnic balance is maintained in the staff of RCMA centers, so that migrant children are cared for by Blacks, Hispanics, and Whites. The RCMA staffing is based on the conviction that former migrants are the people best equipped to serve current migrants and that children will benefit from receiving care and attention from people of diverse ethnic and racial backgrounds. It would be difficult to overemphasize the merit of the RCMA day care program and the degree to which former migrants are involved in formulating and implementing that program. To date, the Catholic Services Bureau provides only limited services to migrants in Immokalee. Services include foster care, counseling, a big brother program, emergency assistance, and outreach. However, the organization has hired a former migrant as a community aide to work with migrants to provide outreach services. A migrant also participates on the Bureau's advisory board, and it is expected that the organization will expand its services to migrants in the near future. The activities of RCMA and the Catholic Services Bureau are unusual because it is somewhat rare for private organizations other than farmworker organizations to be actively involved in service delivery to migrants, and it is even more rare for such organizations to hire migrants to serve migrants and to include migrants on their advisory boards. The service activities and staffing of RCMA and the Bureau demonstrate a high degree of consciousness of and sensitivity to the situation of migrants and a commitment to work actively in response to the needs of migrants.

There are two farmworker organizations serving Immokalee: the Community Action Migrant Program (CAMP) and Organized Migrants in Community Action (OMICA). Both organizations include on-the-job training and manpower programs, emergency assistance, outreach and referrals, family counseling, and facilitating access to food stamps. Each organization offers different additional services. Although there are many apparent similarities between these two organizations and their programs, an on-site visit in October 1976 revealed a number of fundamental differences between CAMP and OMICA. CAMP is a predominantly Black organization and the majority of its clientele is Black, although the organization also serves Hispanic and White farmworkers. OMICA is predominantly a Mexican American organization with a Hispanic orientation, although it also serves farmworkers of diverse racial and ethnic backgrounds. Representatives of various social service provider agencies in Immokalee stated that CAMP was a highly bureaucratic organization and was only minimally involved in advocacy for farmworkers. When OMICA was formed in the late 1960s, its activities focused on unionization of farmworkers. At present, OMICA operates as an advocate and a provider of social services to farmworkers. The organization is affiliated with an ongoing unionization effort conducted by a separate corporate structure. By late 1976, it was clear that OMICA and CAMP were engaged in a competition for federal resources to provide social services to migrants in the area.

In January 1977, the Department of Labor refused to renew $1,500,000 in funding for CAMP. The effect of this funding cut with regard to manpower and supportive services for migrants is immediate. The ultimate effect of this defunding on the future of CAMP is not yet known. It is possible that the DOL funds will be transferred to the state education agency which could then subcontract with other agencies for adult manpower training services.

Service Delivery

The diversity of service provider agencies and types of services targeted to migrants tends to mask a number of serious problems that affect migrants and service delivery in Immokalee. Simply put, the services offered to migrants in Immokalee are insufficient for meeting the needs of the migrant population. With the exception of Title I Migrant Education programs, most services reach a limited number of farmworkers relative to the total migrant population. Staff of the migrant health clinic estimated that their services reach between 20% and 50% of the migrant children in Immokalee. The Department of Family Services (DFS) reported that their programs serve approximately 50% of the migrant child population in Collier County. A 1970 study found that only 5% of the migrant children in Immokalee who entered school in the early 1960s reached the twelfth grade in the 1970s (Florida Migrant Labor Program, "Farmworkers in Florida," p.9). Housing programs are available to very few of those migrants in need of improved housing. Although both CAMP and RCMA operate day care programs for migrant children, together these providers serve approximatley one-seventh of the children eligible for day care. Certain services, such as infant care and before- and after-school care, reach even smaller proportions of the eligible clientele. Hospitalization and good preventive health care are virtually nonexistent.

Those services that do reach migrants are often inadequate to respond fully to the needs of farmworkers. The only major service agencies which employ former migrants for service delivery are the farmworker organizations, RCMA, and the migrant health clinic. Social services, migrant education, and county health department programs are operated by people who lack a familiarity with the migrant lifestyle that would enhance service delivery. Only 20% of the migrant education staff in Collier County is Spanish-speaking while 70% of the students are Spanish-speaking (National Child Labor Committee, Promises to Keep, p.16). Other service providers, such as the DFS, are inadequately equipped to assist Spanish-speaking clients. Outreach was reported by several service provider staff members to be insufficient. Outreach is critical to effective service delivery among migrants, and a lack of outreach limits the farmworker clientele reached by service providers. In general, staff and program development activities are at a minimum among public service providers. The lack of former migrant and bilingual personnel and insufficient outreach hinder migrants' access to services and contribute to making those services that do reach migrants poor in quality and inadequate for meeting their needs. The absence of staff and program development activities virtually ensures that neither the quality nor the extent of service delivery will improve in the foreseeable future.

Insensitivity to migrants was revealed to a surprising degree by service provider staff members in Immokalee. A local CAMP official used the word "lazy" to describe Mexican American migrants. A staff member at the migrant health clinic described the migrants as "dirty" and stated that they are offensive to other patients. A DFS staff member asserted that the major barriers to social service delivery are the lack of education of migrant adults and the large size of the migrant families. People with such attitudes can hardly be expected to work effectively in the service delivery to migrants and would be far less likely to advocate or strive for improved service delivery to migrants. The negative attitude of service providers represents a formidable obstacle to be overcome in improving the living conditions of migrants in Immokalee.

Funding constitutes another major problem in service delivery to migrants in Immokalee. As elsewhere, funding is insufficient for reaching all migrants eligible for services and for providing farmworkers with adequate, comprehensive service programs. Funding for the migrant clinic from the Migrant Health Act and Rural Health Initiative is being reduced. The Migrant Health Program grant was cut by ten percent in 1975, and further cuts are anticipated. The defunding of CAMP represents a withdrawal of $1,500,000 in resources and programs from southern Florida. If the Department of Labor funds are not channeled to migrants through another agency, this cutback will have serious repercussions for migrants. The few children served by day care, infant care, and other programs reflect insufficient funding. The deplorable housing conditions of farmworkers in Immokalee are visible proof of the lack of funding available for making a significant impact on the lives of the migrants.

The problem of funding in Immokalee has several dimensions. Funds and resources for services to migrants have been both misused and mismanaged. For example, a national study of Title I Migrant Education programs reported that in Collier County, as in other parts of the country, "significant charges were made in the migrant budget for custodial care" (National Child Labor Committee, Promises to Keep, p.28). The transfer of funds targeted for educational services to the plant maintenance budget represents a gross misuse of educational resources and, in this case, discriminates specifically against migrant children. CAMP returned food stamp vouchers to the government because the organization had not distributed the vouchers within the time period during which the vouchers were valid. Thus, CAMP failed to utilize resources already allocated and available for serving migrants within the time allotted. Mishandling or mismanagement of funds or resources underscores the insensitivity to migrants among service providers in Immokalee and raises serious doubts about the quality of services delivered and the commitment of service providers to migrant advocacy. The misuse of funds and the inability to utilize available resources are deplorable under any circumstances, but particularly when funding is insufficient and the need for services is so profound and widespread as in Immokalee.

There is a charged atmosphere in Immokalee. When Florida State Representative John Lewis visited the town in the fall of 1976, he reported, "No one wanted to talk to us there." Representatives of migrant advocacy groups have been threatened by local inhabitants. The director of OMICA was told that his car would be blown up, and he and his dog would be killed; subsequently his dog was killed. A group of Whites held a mock burial of a Black FRLS lawyer in the lawyer's presence and threatened his life. The disdain for migrants expressed by the staff of some service providers surely reflects a widespread negativism or hostility toward migrants. It is possible that the rivalry between CAMP and OMICA is an indicator of tensions within the farmworker community. The racial and ethnic composition of the migrant population in Collier County is shifting, and Hispanic people have recently come to constitute a majority. If Blacks, formerly the majority of farmworkers, are suffering economic dislocations as a result, then it is possible that divisions within the farmworker community could be an outcome of these changes.

Conclusions

It may be considered reasonable to conclude that the situation of migrants in Immokalee is unique and an extreme case. In fact, the problems found in Immokalee are typical of the problems affecting migrants everywhere. The difference is merely one of degree. The problems of migrants have more widespread consequences in Immokalee than elsewhere because of the greater concentration of migrants there. In all the states surveyed, unemployment and economic dislocation are on the rise among migrant farmworkers due to increasing mechanization in agriculture. Bad weather nationwide has caused migrants everywhere to face the prospect of a disastrous year in 1977; Florida was simply the first state to experience severe losses in the agricultural sector which, of course, means unemployment for migrants.

APPENDIX

METHODOLOGY

Throughout this study, the primary objective has been to obtain as complete a picture of the migrant child welfare situation as possible, given funding and time restraints. Although migrants work in all states, it was necessary to limit this study to a sample of states in order to ensure that the results would be an accurate and complete picture of the situation in those areas studied. A decision was made to sample twelve states representative of migrant activity throughout the country as a whole, and inclusive of all three migrant streams (Eastern, Midwest, and Western), all racial and ethnic groups of the migrant community (Anglo, Asian, Black, Chicano, Native American, and Puerto Rican). The sample also included states with large migrant populations and those with small migrant populations, and those that served as home base areas as well as states that served primarily as user areas. The final list of states selected for this study is as follows: California, Colorado, Florida, Iowa, Illinois, Maryland, Michigan, North Carolina, New Jersey, New York, Texas, and Washington. California, Texas, and Florida are large home base states; Michigan serves as both a home base and user state; New York has a large migrant population while Iowa has a small one; states such as New Jersey and North Carolina on the East Coast have a large proportion of Black migrant workers; Colorado has a large number of Native Americans; Illinois is a large user state on the Midwest stream, as is Washington on the West Coast, and so forth.

Maryland was selected as the pretest state. The results of the pretests were highly successful, and a number of changes in the family and agency instruments were suggested by those interviewed. Complete data for all agency personnel were obtained, and several family interviews were conducted in Maryland. However, it was found that numerous changes were needed in the family instrument in order to clarify the information received, and the resultant revised form was sufficiently different from the form used elsewhere so that the Maryland family interviews were not used in the final analysis of the family data.

Due to the size of most of the states, further limitations on the regions to be visited were necessary. Therefore, a decision was made to visit the counties with the largest migrant populations within each state, allowing a comprehensive examination of the available services. The practice of examining the county with the largest population of migrants yielded the maximum amount of data in a minimum amount of time. Visits with state agency personnel yielded information concerning programs administered at the state level.

The final list of survey counties is as follows: California--Imperial and Fresno Counties; Colorado--Weld County; Florida--Collier County; Iowa--Muscatine County; Illinois--Vermillion and Ogle Counties; Maryland (pretest)--Talbot, Somerset, Wicomico, and Worcester Counties; Michigan--Berrien County; New Jersey--Cumberland County; New York--Wayne County; North Carolina--Johnston County; Texas--Cameron, Hidalgo, and Webb Counties; Washington--Yakima County.

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The above list includes one county from each state with the exception of Texas and California, where data were gathered from more than one county due to large migrant populations differing significantly in various parts of each state; Illinois, where family interviews were conducted in two counties in order to obtain a total of 80 interviews as in each of the other states; and Maryland, the pretest state, where interviews were held prior to the decision to concentrate on the county with the largest migrant population in each state.

Agency Questionnaires

The first contact made with each agency was through a mail questionnaire. With the questionnaire were a cover letter and a brochure describing the project, as well as a stamped, self-addressed envelope for return of the completed form. The questionnaire sent to each agency included requests for the following data: number of total children served, number of migrant children served, budget and source of funding, number of bilingual/bicultural personnel, presence of programs aimed specifically at migrants, problems with illegal aliens, frequency of training sessions on the problems of migrants, whether the agency had participated in past studies, and service delivery to migrants.

In addition to these questions, most questionnaires also contained agency-specific questions. For example, migrant health clinics were asked questions about referrals to local hospitals or public health facilities, while farmworker organizations were asked about the availability of telephones for emergency use in the local camps.

The agencies selected to receive questionnaires were state and local service delivery organizations in the study regions. An attempt was made to contact all organizations likely to serve the migrant population, or that might include migrants in their service delivery target populations. Within each area, the following organizations received mail questionnaires: state--public welfare agency, division of protective services, Title I Migrant Education office, health agency, migrant affairs office, county--health department, public welfare office; and local--Local Education Agencies with Title I Migrant programs, farmworker organizations, migrant health clinics, and voluntary organizations likely to serve migrants.

After the mail questionnaires were distributed, a brief follow-up telephone call was made to each agency other than the Local Educational Agencies with Title I Migrant programs. (Due to the large number of LEAs only a small percentage of them received further contact after the mail questionnaire was sent.) The purposes of the follow-up telephone call were twofold. First, it impressed upon agency personnel the seriousness of the intent of the study, and InterAmerica's desire to receive the completed questionnaires; second, it provided an opportunity to arrange for a personal interview by a member of the InterAmerica research staff.

The personal interview was conducted with each agency that received a mail questionnaire (with the exception of most LEAs), plus additional local agencies that surfaced during the visit to each state, including day care centers, Head Start Projects, state public welfare regional offices, church-sponsored projects, and Community Action Programs. In addition, some state migrant affairs offices were independent of the state Department of Social Services, and had not received a questionnaire; the directors were contacted and interviewed personally.

The nature of the personal interviews and the collected data differs somewhat from the mail questionnaires. Rather than concentrate on numerical data, as the mail questionnaires did, the personal interviews concentrated on qualitative data such as problems in service delivery to migrants, and how those problems might be solved. Also noted were factors such as the agency's perception of the extent of the migrant community's need for services and the degree to which that need was being met, the agency's perceived willingness to deal with migrants and to make special efforts to meet their unique needs, interagency coordination, and so forth. Thus, the personal interviews provided the opportunity to evaluate how well migrants were being served, and also how willing the agencies were to try to serve migrants. Many agency personnel showed interest in the plight of migrants and concern over the lack of long range planning--a problem not mentioned on the questionnaire but nonetheless important.

Data reduction of the agency questionnaires took several forms. Some information, such as the number of states providing each service, was tallied. Tallying was most applicable to the mail questionnaires due to their quantitative nature. In addition, topic area outline forms were developed, which covered the topics of education, day care, undocumented workers, effectiveness of Title XX, advocacy, child welfare services, program management, environmental health, personal health, and child farm labor. Requested on these topic area outline forms was any relevant information, qualitative or quantitative, gathered during the personal interviews or mentioned on the mail instruments. These forms provided a unique opportunity to condense a large amount of information into a brief, highly usable format. The combined results of the mail and personal interviews give a broad base of information, encompassing both hard and soft data. Therefore, not only statistics, but also such factors as problems in service delivery and interagency coordination enter into the description of the agencies. Thus, the agency information is quite comprehensive.

Family Interviews

As with agency interviews, families who were interviewed resided in the counties with the largest migrant populations. Interviews were conducted by individuals recommended by the farmworkers' organizations in each state. In many cases, this manner of selecting interviewers yielded well-experienced individuals, and, in all cases, the interviewers were quite knowledgeable about the migrants in their areas. The interviewers were all of the same ethnic or racial background as the migrants they interviewed and the interview was conducted in the migrant's home language. There were generally two interviewers in each state, but a few of the larger states had three or four. The interviewers were trained together at a two-day training session in Chicago, conducted by the project staff, and the interviewing began soon after training.

A goal was set of eighty family interviews in each state, to total 880 interviews. No attempt was made to provide a random sample because no practical method exists by which a random sample of known migrants could be drawn, and also because the interviewing began late in the season in many states, after many migrants had already begun returning to their home base. Instead, the interviewers were requested to conduct interviews wherever migrants could be found in the county. It is possible that the sample was somewhat biased toward those persons who did receive services, as some interviews were held in public places where migrants were likely to be reached, such as migrant health clinics and day care centers.

Besides interviewing 80 migrant families in each state, the interviewers were also requested to interview settled-out migrants wherever possible. The results of this part of the survey were only partially successful; most interviewers had great difficulty in locating settled-out migrants, except in a few states with large, easily identified, settled-out populations. Thus, the total number of settled-out migrants interviewed is small and generally concentrated in a few states.

The interviews lasted no more than 20 minutes, although informal conversation before and after the interviews often extended the total time the interviewer spent with each respondent. Plans originally called for interviewing mothers in laundromats, where it was felt that respondents would be most easily accessible. In many cases, however, interviews were held in other places, such as the camps or homes, or, in some cases, in day care centers or migrant health clinics. In general, the interviewers were sufficiently knowledgeable about migrants that they were able to locate respondents easily in places where migrants felt comfortable discussing their situations and problems. Most interviewers reported that the interviews went very smoothly, and that the respondents were quite cooperative, often volunteering to talk at length about their own childrearing experiences.

After the interviews were completed, the returned forms were mailed from the field to InterAmerica headquarters in Washington, D.C., for coding and processing. When 30% of the questionnaires had been received, a coding system was developed for the open-ended questions. After all the questionnaires had been coded, the data were keypunched and verified, and processing was begun.

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FREQUENTLY USED ACRONYMS AND ABBREVIATIONS

AFDC - Aid to Families with Dependent Children

CAP - Community Action Program

CETA - Comprehensive Employment and Training Act

DOL - Department of Labor

DSS - Department of Social Services

ECMP - East Coast Migrant Project

EPSDT - Early, Periodic, Screening, Diagnosis, and Treatment

ESEA - Elementary and Secondary Education Act

FIDCR - Federal Interagency Day Care Requirements

HEW - Department of Health, Education, and Welfare

IMPD - Indian and Migrant Programs Division

LEA - Local Education Agency

MCH - Maternal and Child Health program

MLAP - Migrant Legal Action Program

MSRTS - Migrant Student Record Transfer System

NMRP - National Migrant Referral Project
(computerized health referral system)

OCD - Office of Child Development

OSHA - Occupational Safety and Health Act
Occupational Safety and Health Administration

PAC - Parent Advisory Council

SEA - State Education Agency

USDA - United States Department of Agriculture

WIC - Special Supplementary Food Program for Women,
Infants, and Children

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